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ORIGINAL COMMUNICATIONS.

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JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XX. MAY, 1902. No. 5.

Original Communications.

A PRELIMINARY REPORT OF TWO CASES OF CUTANEOUS BLASTOMYCOSIS (BLASTOMYCETIC DERMATITIS OF GILCHRIST).

BY FRANK HUGH MONTGOMERY, M.D.,
of Chicago.

CASE I.—The patient was sent to my clinic, at the Chicago Clinical School, by Dr. William L. Noble, of the Illinois Eye and Ear Infirmary. To Dr. La Force, interne of the infirmary, I am indebted for the following history:

"Mrs. A. M., age twenty-eight; Bohemian; occupation, housework. Father, aged fifty-five, living and well. Mother died of consumption at fifty. Three brothers living and well; five sisters, three of whom are living and well; one died at two years, of pneumonia, and another at seventeen, of consumption. Has had the usual diseases of childhood. No specific history. Married at sixteen. Mother of three children; first living and well; second, died when fifteen days old; third, seventeen months old, living and well. During the latter half of her last pregnancy, had a bad cough and spit up considerable blood. Also during her last pregnancy had an eruption over her body, and in its course an abscess formed in the left inguinal region and another on the right forearm. About the time this eruption disappeared the present trouble commenced, which was twenty-two months ago. The right upper eyelid became swollen and painful. The swelling ruptured just below the eyebrow, and considerable pus discharged. The process gradually advanced from the original site, infiltrating new areas and forming a ridge, cauliflower-like in appearance in places, while other parts were covered with crusts. While the process advanced, it healed

at the original site, leaving a scar tissue. She was treated in the hospital at Joliet last December, for four weeks, with no improvement. Came here December 30, 1900. Condition on entrance: Emaciated and run down. Right eye, marked ectropion, exposing whole cornea. Lower border of upper lid drawn up to the eyebrow. Corneal ulcer from lagophthalmus. Large scar involving right eyebrow and cheek. The process extends across the nose on left cheek, and from the middle of the forehead, just below left eyebrow. Where the process is advancing is a ridge three-eighths of an inch high, cauliflower-like in places, while in other places it is covered with crusts, beneath which a small amount of pus is found.

"No evidence of syphilis or tuberculosis on general examination. Treatment: Potassium iodide 60 gtts. (sat. sol.) t.i.d., increased 2 gtts. daily to 120. Patient commenced to improve at once."

It was exceedingly difficult to obtain a satisfactory history from this patient, as her intelligence was of a low order, and, as she did not speak English, all conversation had to be conducted through an interpreter. On several subsequent occasions, however, she was carefully questioned in an effort to learn the nature of the eruption and the abscess above mentioned as occurring during her last pregnancy. Although her statements at different times varied considerably regarding the time of appearance and duration of the eruption, she always declared that it had itched very much, and that it had been better at times and worse at others, sometimes nearly disappearing; that it was usually dry, but after scratching more than usual there would be moisture and crusting. The abscesses were evidently of brief duration, and were probably due to a local pus infection following traumatism with the nails, as the patient was not cleanly in her habits and her hygienic surroundings were poor. The scars left by the abscesses are irregular and insignificant, and do not suggest either syphilis or tuberculosis.

On examination January 30, 1901, it was seen that the disease involved the following areas. There is marked ectropion of the right eye, the lower lid being destroyed, and the upper everted and its lower border attached to the eyebrow. The cornea is entirely exposed, and the seat of ulceration. The sight is destroyed. Surrounding the right orbit is a sharply-defined area, for the most part about an inch in width, of soft, smooth, pinkish-white scar tissue. The upper two-thirds of the nose and the inner canthus of the left eye are covered by the same sort of a scar. Active areas of the disease are present as follows: An irregularly circular, verrucous ridge occupies the middle third of the lower half of the forehead, from which a branch extends horizontally along the middle of

the upper left eyelid. An irregular ridge, varying in height and width, extends nearly horizontally along the middle of the right cheek, over the nose, just above the tip and alæ, which are spared, and terminates half an inch below the middle of the lower border of the left orbit. These active areas are elevated from one-eighth to a quarter of an inch, are papilliform and verrucous in character, and covered in places with more or less bulky crusts. A few portions are fairly firm and dry, but most of the areas have a soft base, and slight pressure causes pus to ooze up between the papilliform projections. The outer border of all the lesions is sharply defined, but separated from the normal skin by a sloping, purplish border, an eighth to one-fourth of an inch wide, in which are seen miliary abscesses. On being opened, these minute abscesses give exit to viscid muco-pus.

The scar of the older lesions is soft, smooth, supple, and not attached to the deeper tissues. The more recent scar below the right orbit and in the clearing area on the forehead is thick, firm, somewhat irregular, and, on close inspection, is seen to contain a few miliary abscesses like those of the violaceous border surrounding the active lesions.

Pus from the abscesses, and scrapings from the interior of a soft nodule, examined in a solution of potassium hydrate, showed characteristic round, highly refractive bodies, with the double-contoured capsule, and, for the most part, a granular protoplasm. Budding forms were present, but no mycelium.

The treatment instituted by Dr. Noble was continued and the patient kept, with a few brief intermissions, on one hundred grains of potassium iodide three time a day. She was also given tonics, and the surface covered with a wet boric-acid dressing. The lesions rapidly disappeared, until, on May 20th, neither papilliform elevations nor miliary abscesses could be detected. All but the most recent portions of the scar had become smooth, soft, and non-attached. She was advised to continue treatment until all this scar tissue had disappeared, and then to have an operation to overcome the ectropion.

Histopathology.—With a few minor exceptions, the tissue changes are the same as those described in Case II. The small piece of tissue was taken for examination from a part which was healing under the influence of potassium iodide, and included but a small portion of the active verrucous border. The sections consequently show some scar tissue, less epithelial hyperplasia than in Case II., but few of the characteristic abscesses, and less evidence of acute inflammation, but more and larger giant cells than in Case II. The organisms are not numerous. They average about 10 μ. in diameter, and have the usual double-

contoured, resistant capsule and granular protoplasm. Budding forms are seen.

Cultures.—Scrapings from one of the small nodules, the surface of which had been cleansed with alcohol, and pus from miliary abscesses were used to inoculate different media at different times. On several media a mould fungus developed in from three to seven days. The fungus grows readily on almost all ordinary media, of which glycerin and glucose agar seem to be, on the whole, the most satisfactory. The following description refers to the growth on these two media:

The original cultures appeared as round, slightly radiating or stellate colonies of a white, fluffy growth, showing short aerial hyphæ, also similar hyphæ extending into the media to a depth of one one-eighth or a quarter of an inch. After several weeks the cultures became slightly yellowish or yellowish-brown in color. Subcultures appeared in two forms, the majority having the same characteristics as the original culture, except that the tendency to penetrate the media was less apparent, and in the third generation was lost entirely, though the colony in every instance is intimately and firmly attached to the media. A few of the cultures were like the original, except that instead of being fluffy with aerial hyphæ they were moist and slimy in character, in two instances having a very light, yellowish-brown color from the beginning. These two cultures showed at the center a slightly granular appearance. At the end of four weeks this granular center was raised a quarter of an inch, and from it there extended to the circumference irregular but smooth folds and grooves, suggesting some colonies of the trichophyton.

The variations here noted are similar to those seen in other fungi, and may have been due to slight differences in the media or in other conditions. It is possible also that in this (and in other cases previously reported) there is more than one variety of a given species of fungus present.*

Under the microscope the fungus, both from the dry and from the moist colonies, presents fairly uniform pictures. Colonies but two or three days old show chiefly a fine, tangled mycelium, the hyphæ being very long, straight or slightly curved, and either homogeneous or showing a few refractive granules scattered through the center. Few branches at acute or nearly right angles are seen. As the colony grows older, the mycelium becomes thicker and shorter, shows a distinct capsule and segments of varying length, in each of which are seen one or several spore-like bodies. After a varying period of time—ten to twenty days—long filaments are very few, the growth consisting of

* A systematic study of this organism and of those in several other cases is now in progress and will be reported later.

short, jointed mycelium, varying greatly in size and shape; of pods of various shapes and sizes, and of round, ascus-like bodies described in the next paragraph (Fig. 1).

In original cultures the older portions of mycelium showed sessile or pedunculated, circular, double-contoured bodies (ascus-like), containing from three or four to a dozen highly refractive spherical bodies of fairly uniform size. For convenience in description, these are here termed "sporules." No free cells were visible during the first two

Fig. 1

weeks. At the end of six weeks one of the original cultures showed free circular bodies, with double-contoured capsules, and filled completely with "sporules." In the subcultures a few ascus-like bodies attached to the mycelium are seen within three days after the appearance of the growth. They gradually increase in number and in size, and send out variously shaped buds or projections, both before and after becoming detached, which develop into short, thick, segmented conidia, more or less filled with "sporules." The circular bodies gradually increase in size and in number, the majority of them being filled com-

pletely with "sporules." Some of these, however, contain from one to three or four larger circular, oval, or irregularly shaped bodies, the shape of which can be made to vary by pressing on the cover-glass of a moist preparation (Fig. 2).

In two or three cultures, that have been examined also by Dr. Hyde and Dr. Ormsby, the older capsules—or ascus-like bodies—have become partially or entirely empty of sporules, the latter appearing in groups outside the capsule, the number outside corresponding to the number that would be necessary to fill the capsule. In several instances the sporules, both within the partially filled capsule and without it, have exhibited Brownian movements. Rupture of the capsule with escaping sporules has been demonstrated in two short pods only, but prolonged observation of hanging-drop has not yet been successfully carried out.

Case II.—Mrs. M., æt. fifty-one, consulted Dr. Hyde February 12, 1900. The patient is a German woman in good general health, and of good habits. In a carefully obtained family and personal history nothing could be found suggesting previous or present syphilis, tuberculosis or malignant disease. She has had seven children, the third and the fourth dying in infancy from acute disease, the exact nature of which she did not know. She is unable to throw any light on the cause of the present disorder of her skin.

Her cutaneous disease began in January or February, 1898, as a small red spot on the back of the hand, over the head of the first metacarpal bone. The spot became slightly swollen, and upon it developed a pimple, which in a short time became a pustule. This ruptured, and formed a crust. Other pimples and pustules appeared and spread, until in the course of six or eight months nearly the whole dorsal metacarpus was covered with a somewhat swollen and irregularly crust-covered surface which was more or less infiltrated with pus. In about a year from the time of the appearance of the first lesion healing began in the center, while the disease was yet extending peripherally, and has slowly and steadily progressed up to the present time, until all the involved surface except three small areas is replaced by soft scar-tissue. Six months prior to this examination, a new area appeared on the flexor aspect of the wrist, on the radial side, and a few weeks ago a small lesion on the ulnar side. The patient says that during the past two years "pimples" have appeared from time to time on the forearm. These disappeared, however, without treatment, and without leaving either scar or persistent pigmentation. She states that none of the lesions have ever been more than slightly painful, though they are sensitive to the touch.

On examination, there is seen on the radial side of the flexor aspect

of the forearm, about an inch above the wrist, a lesion roughly circular in form and nearly an inch in diameter. A second lesion, about a quarter of an inch in diameter, is seen near the first, on the ulnar side of the forearm. Three irregularly oval or circular lesions, varying in size from a half of an inch to an inch in diameter, are seen, respectively, over the proximal and distal extremities of the first metacarpal bone and over the distal extremity of the fifth metacarpal. The larger lesion on the forearm is irregularly elevated from a fourth to a quarter of an inch above the epidermis, and is bounded by a reddish-purple areola, which slopes off to the normal skin. In this areola are seen a number of minute, deep-seated abscesses, barely visible to the unaided eye. The lesion itself is covered with an irregular, bulky, dirty, tenacious, closely adherent crust. On removal of the crust, the surface beneath is seen to be made up of many papilliform, verrucous elevations, which are intensely red, and bleed easily. If these papillæ are clipped off with the scissors, free hemorrhage results. In the clefts or depressions between the papillæ there is a collection of pus, which is very readily increased in amount by a slight pressure on the mass, the pus oozing out from the beneath the surface. The lesions on the dorsum of the hand are very similar in character to the one above described, all presenting the elevated, papilliform or verrucous surface, covered with a crust, and surrounded by the sloping violaceous border, in which can be detected miliary abscesses.

The scar left on the dorsum of the hand is soft, supple, non-attached to the deeper tissues, lighter in color than the normal skin, and, in general, smooth. The whole is traversed, however, by a close network of fine lines of whiter, denser, scar tissue, producing to the eye a cribriform appearance, which can also be detected on delicate palpation.

Examination of Fresh Specimens.—Pus from the minute abscess in the areola, also pus expressed from the base of the ulcer, as well as some of the verrucous tissue and crusts, were mounted in a strong solution of potassium hydrate and studied. In pus from the abscesses and in the tissue characteristic spherical, resistant cells were seen, having a double-contoured capsule and central protoplasm. Many budding forms were present. Some of the cells contained vacuoles, while a number contained several highly refractive globular bodies. The diameter of the organism averaged about 9 μ.

The woman was put on the iodide of potassium, with the result that the progress of the disease was arrested and portions of the active lesions were slowly transformed into scar tissue. She was unable, however, to take the iodide in larger doses or in moderate doses regularly,

and fifteen months after beginning treatment a few small, active lesions were left.

Histopathology.—In the essential features this case corresponds with the published cases of this disorder, the following points being especially conspicuous: The surface is markedly irregularly papilliform. The rete is the seat of extensive hyperplasia, sending down processes deep into the corium. These epithelial processes are exceedingly irregular in size and shape, and send out branches in all directions. They also contain many of the characteristic miliary abscesses. The corium is the seat of a more or less diffuse cell infiltration, distributed through the upper two-thirds of the corium, and extending in places to the subcutaneous tissue. This cell infiltrate is very much intensified in certain areas, which, however (aside from the abscesses), are not distinctly circumscribed. A slight amount of infiltration is found at some distance from the areas chiefly involved, and is seen especially about the vessels.

The histological features in greater detail are as follows:

The surface is more or less covered with blood, exfoliated cells, and amorphous matter.

The horny layer varies greatly in thickness, being entirely absent in places, and consists for the most part of loose lamellæ. In many of the deeper cells nuclei are present.

The stratum lucidum is wanting.

The stratum granulosum is wanting in places, and in others varies in thickness from one to four layers of cells.

The rete is the seat not only of the hyperplasia above described, but also of edema, both inter- and intra-cellular, in consequence of which the inter-cellular spaces and the prickles are very conspicuous. Besides the presence of miliary abscesses, there is a diffuse infiltration of leucocytes, chiefly polymorphonuclear, between the cells of the rete. The abscesses are characteristic of the process, varying in size from the smallest possible accumulation of leucocytes to abscesses large enough to be visible to the unaided eye. They are situated wholly within the epithelial processes, and their walls are made up of flattened epithelial cells. Some of the larger abscesses communicate with the corium or with the surface. The abscesses contain chiefly polymorphonuclear leucocytes, also many epithelial cells of various shapes and in various stages of degeneration, some red blood cells, nuclear fragments, granular débris which takes the stain poorly, an occasional small giant cell, and the organism. The epithelial cells are, for the most part, swollen and edematous. Abnormal cornification is not so marked as in some cases, but does occur in individual cells and in incipient whorls.

The columnar cells of the basal layer are present in all the epithelial processes.

The corium is also the seat of marked edema, and is for the most part decidedly vascular, but where the infiltration is densest the vessels and appendages of the skin have disappeared. The papillæ are absent or distorted. The vessels are dilated; all the coats are thickened, including the intima. The vessels are thus affected where the infiltration is very slight or practically wanting, except for a small number of proliferated connective-tissue cells about the vessels. The coil glands are dilated, and frequently surrounded by infiltrate. In the areas of dense infiltration the collagen and elastin are almost entirely destroyed, a few elastic fibers and an occasional fibrous bundle remaining. There are numerous miliary abscesses.

The infiltrating cells are leucocytes, chiefly polymorphonuclears, plasma-cells and mast-cells. The plasma-cells are most common in the outlying, less acute, areas of infiltration. The mast-cells are numerous, and with the polychrome methylene-blue take the red stain very deeply, in some instances obscuring the granular character of their protoplasm. Giant-cells are small and present in very small numbers, many sections showing none at all, either in the cutis or epithelial abscesses, or in the general infiltration.

The organisms are not very numerous, but are found in pairs and in budding forms in the epithelial abscesses and in infiltrate of the cutis. They have not been found in giant-cells. The organism averages from 8 to 10 μ in diameter, and possesses the usual double-contoured capsule and a granular protoplasm, which, in some instances, is separated from the capsule by a clear space. One or more vacuoles are seen in some of the organisms.

Cultures.—Different media were inoculated with pus and teased tissue. On two different occasions a pure culture of a mould fungus was obtained from the muco-pus from the smaller abscesses. As is usual in these cases, cultures obtained from teased tissue were contaminated. In gross appearances, and as studied under the microscope in smear and in hanging-drop, this fungus appeared to be very much like that of the preceding case; but, as we did not succeed in growing subcultures, the organism was never satisfactorily studied.

Animal experiments have yet to be made. No tubercle bacilli could be found in sections stained for the purpose.

ACNE AND SYCOSIS TREATED BY EXPOSURES TO ROENTGEN RAYS.

By Wm. Allen Pusey, A.M., M.D.,
Professor of Dermatology in the University of Illinois, Chicago.

OUDIN, Barthelemy and Darier* have shown in studies of alopecia in guinea-pigs, produced by Roentgen rays, that the effects on the epithelial structures of the skin are to increase the vitality of the least differentiated skin elements, while the differentiated elements, nails, hairs and glands, undergo retrogressive changes and atrophy. That these atrophic changes in the appendages of the skin occur is abundantly confirmed in the macroscopic changes in skin exposed for a considerable time to the effect of X-rays. Another property of X-rays is their inhibitory effect upon the formation of pus in the skin. This property of X-rays has been shown in the reports of a number of observers, and the writer has repeatedly seen it illustrated in the cleaning up of ulcerating surfaces exposed to the effects of X-rays. These two effects of X-rays, the atrophy of the cutaneous follicles which they produce and the checking of pus formation, furnish good pathological grounds for suggesting *a priori* the use of the agent in the treatment of acne. My observations upon this subject were first made in cases having slight acne, which were under treatment primarily for hypertrichosis. Following this hint, I began, in August, 1901, to treat intractable acnes by exposures to X-rays. I have used the method in a number of cases, and the results are, I believe, of interest.

Case I.—Miss A., age twenty-two, black hair, with fair skin. This patient was put under exposures to X-rays in July, 1900, for hypertrichosis. On the chin and around the mouth she had an acne simplex, of moderate severity. The lesions were usually indolent, inflammatory papules, without much induration and rarely with the formation of well-marked pustules. During July, August and September, 1900, this patient was under exposures to X-rays, with a production of some dermatitis, and she has been under similar treatment at intervals during the last year. After the development of the first erythema her acne disappeared, and she has had no lesions within the last year.

Case II.—Miss B., age twenty-six, pronounced brunette. This case

* Monatsheft f. prakt. Dermat. XXV., 9, 1897.

is identical in all essential details with Case I. The patient began treatment January 17, 1901, and has had practically no acne since the production of the first slight erythema, a year ago.

Case III.—Miss C., age twenty-six, with fair skin. Began treatment June 28, 1901, for hypertrichosis. This patient had suffered for a long time from a slight acne about the chin, with a considerable number of comedones and constantly recurring outbreaks of a few indolent, inflammatory papules. She had been more or less constantly under my care for several years for this acne, and I had never succeeded in entirely relieving her of it. Since the production of the first erythema, in September, 1901, she has had no acne lesions.

All three of the above cases have been constantly under observation. They have had X-ray exposures at intervals during the last year for hypertrichosis, so that the effect of the X-rays upon the skin has been maintained. In all of these cases the skin is smooth, soft, and the result is satisfactory from a cosmetic point of view. There is evidently slight atrophy of the skin in each of these cases. In each there has been some pigmentation produced at one time or another by the X-ray exposures, but in none of them has this pigmentation been persistent.

Case IV.—Miss D., age twenty-three, came to me July 20, 1901, for an indurated acne of the lower part of the face and on forehead. I had the patient under ordinary methods of treatment from July 20th to August 26th, in spite of which lesions continued to develop, and on August 26th I suggested to her that we try the effect of exposures to X-rays. She was given exposures to X-rays from August 26th to September 26th, having eighteen exposures in all, with a very weak light, with the tube fifteen cm. distance, and the length of the exposures five minutes. Under these exposures, in the course of two weeks, the disease began manifestly to improve; after a month there were no active lesions left. This patient had no sittings between September 26th and December 21st, and had no local treatment except that she washed her face once a day with a one-half-per-cent. bichloride soap. She returned December 21, 1901, and had daily exposures until January 3d, ten in all, without the production of erythema. She advises me now that there has been no further trouble from the acne. Since she stopped treatment, September 26, 1901, there has been the occasional appearance of a single small papule, but she has been practically free from the disease. Up to the time that the acne was affected by X-rays there had been no time in twelve months when there had not been a crop of pustules or papules on her face.

Case V.—Miss E., age twenty-three, referred to me by Dr. Moreau Brown, of Chicago, with an indurated acne of two years' duration.

This was a typical, very severe, indurated acne, with a great number of deep-seated pustules and many scars. The disease had persisted for two years. She was under X-ray exposures more or less regularly from September 16 until December 30, 1901, receiving in all twenty-nine exposures. On October 8th I made the memorandum, "The acne is certainly improving." On November 11th, after the development of slight erythema, there were very few pustules to be found, and the face was smooth and clean. Since December 1st she has been practically free from all manifestations of acne. The change in this case can hardly be exaggerated. Instead of a wretched, intractable, disfiguring acne, this patient now has a clean, healthy-looking, pink skin. There are, of course, numerous scars left, but no other evidence of acne. This patient, for a short time at the beginning of treatment, used lotio alba and a pill of iron, arsenic and strychnine. These had no effect previous to the use of X-rays.

Case VI.—Miss F., age twenty-nine, with a very severe rosacea and many deep-seated pustules and comedones about the nose and flush area of the face. The case presented the picture of a severe acne rosacea of several years' duration, but without hypertrophy. Her health is good, except for constipation, which she had given intelligent care before this treatment began without effect. This case has had exposures from December 9, 1901, to March 19, 1902, thirty-three in all. For a short time she used lotio alba, but after the first two weeks of treatment this was discontinued. The result in this case has been the entire disappearance of pustules and comedones since the middle of January. She still has some rosacea, but this is greatly improved and the face is clean, smooth and healthy looking.

Case VII.—Miss G., age twenty, with a sluggish, pasty skin. During the last year she has been annoyed by comedones and a fairly severe acne about the chin and lower part of the face. This patient had seventeen X-ray exposures between December 13, 1901, and January 23, 1902, with almost entire disappearance of the disease. She has still an occasional comedone, but has not for two months had an acne lesion.

Case VIII.—Miss H., age sixteen, with a very severe juvenile acne. It was a typical, very severe, simple acne, with great numbers of comedones, and superficial pustules. The disease had persisted for two years practically unchanged, in spite of constant treatment. From January 2d to date she has had thirty-six X-ray exposures, with a very great improvement in her condition. She still has a few pustules and comedones, but the face has cleaned up in a remarkable way.

Case IX.—Mrs. J., age thirty-five, spare built, anemic woman, with

constantly recurring crops of inflammatory papules about the chin, and a few comedones. She was under my treatment for two months, with very slight effect, when, on January 2d, I began exposures to X-rays. Between January 2d and February 8th she had twenty-seven exposures, with very considerable improvement in her condition. Treatment in this case was unavoidably discontinued. The improvement in this case was satisfactory to the patient, but it was less definite than in any of the other cases.

Case X.—Miss L., age twenty-four. She has had for five years a very indolent, deep-seated acne. The skin was pale and sluggish, and the cheeks were covered with bluish, deep-seated, indolent lesions. The lesions in this case were extremely indolent, but without a great tendency to the formation of pus. She was put under X-ray exposures January 3d, and to date has had forty-one exposures. There are still a few small lesions left, but almost no comedones, and the face is smooth and clean, and of much better color.

Case XI.—Miss M., age eighteen, referred to me by Dr. D. A. K. Steele. Healthy, vigorous young woman, with a moderate but very persistent juvenile acne. There were not many large comedones in this case, but the patient had constantly recurring crops of indolent, inflammatory papules, without much elevation, and very slow to disappear. This patient has been in the hands of many excellent dermatologists, without at any time entire disappearance of the disease. She was under my treatment for five weeks without material change. She was then put under X-ray exposures, between January 10th and February 27th having twenty-five sittings in all. By February 17th she showed slight pigmentation; there were then no acne lesions present, and only a few stains. Since that time there has been constant improvement in her condition. She has had no lesions develop during the last month, an experience that she has not had before within two years. The slight pigmentation has disappeared, and the skin is perfectly smooth and healthy looking.

The physical condition of these patients was about such as one usually sees in these cases, digestive disturbance in some of them, and some of them anemic. The only one of them that showed any marked departure from health was Case X. This patient has a moderate chronic diarrhea, and for several years has been very anemic. At beginning of treatment she showed 50 per cent. hemaglobin. This patient has had at the same time internal treatment along usual lines, with only slight improvement in her physical condition. Excepting this one, these patients have had practically no internal and no local treatment while under exposures to X-rays.

The above are consecutive cases, and the results are unique in my experience. The results are so direct and so constant in all of the cases that I think there is little room for doubt that they must be attributed to the effect of the rays. In no case thus far that has been under treatment long enough to expect results have I failed to be able to see a beneficial effect from the treatment. If any conclusion may be drawn from so small a group of cases, the method is an advance over any other way of treating acne with which I am acquainted. Of course, it is not suggested that this method should be used to the exclusion of other aids in the treatment of acne. I have avoided opening pustules and giving the patient antiseptic applications or other local treatment, and have also, as far as possible, avoided giving any internal treatment, in order that the effect of the X-rays might be as conclusively shown as possible, but there is, of course, no reason why these patients should not have the benefit of other procedures in their treatment, while still having the exposures to X-rays.

The indications to be met by the use of X-rays are to cause atrophy of the dilated sebaceous follicles and the prevention of pus formation. In no case has there been any undesirable effect on the skin. The skin is left smooth, soft, and clean looking. I have, in one or two instances, seen pigmentation which persisted for a few weeks, but never any that caused serious annoyance. Occasionally the erythema has been quite noticeable for a few days.

There is no other affection which I have undertaken to treat with X-rays that has proven so tractable as acne. The results have been produced quicker, and with less effect upon the tissues that I should have imagined was possible when I first undertook the treatment of the cases.

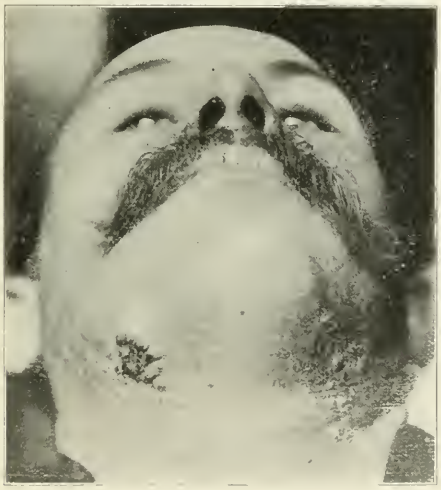
All of these cases I have exposed to a very weak light, using a fairly soft tube and as weak a current as would illuminate the tube. These cases have proven more susceptible to the effect of X-rays than the average. The treatment has in each case been stopped at the first sign of pigmentation or erythema, and in no case has improvement failed to appear simultaneously with the development of these evidences of the effect of the X-rays upon the tissues.

Of course, in treating a cosmetic difficulty like acne, the greatest caution must be used to avoid untoward effects, and the susceptibility of these patients to X-rays has been so marked in my experience that I do not feel like recommending the treatment without a warning against the use of anything but the weakest light in carrying it out. A light that is just sufficient to show as a faint green glow in the tube has, in my experience, proven entirely effective. I am sure that such a

light, when used with caution, is perfectly safe in these cases, but I think that if they are exposed to a strong light it should be with the very greatest care.

In this connection I wish to report a case of sycosis, because the same two properties of the rays of inhibiting the formation of pus and causing atrophy of the follicles of the skin come into play.

Fig. I.



Man, age thirty-five, street-car driver, referred to me by Dr. Henry F. Lewis, of Chicago. His condition at the time he came under my care is shown in the accompanying photograph (Fig. 1). The case was a simple sycosis of moderate severity; there was no ringworm fungus present. The skin was indurated and boggy, with gaping hair follicles filled with pus, and at one point there was a mass of exuberant granulations forming a tumor the size of a mulberry. The disease had persisted for eight months in spite of vigorous local treatment. The case was given no local treatment, except that the patient was told to wash off the surface twice a day with soap and water and to protect it with

cloths spread with boric-acid vaseline. He was put under X-ray exposures November 4th, but there was practically no improvement up to the middle of January. At that time a very slight dermatitis was produced. The sittings were cautiously continued until the dermatitis became rather acute, and on January 23d they were discontinued. By February 1st there was complete alopecia over the exposed area. After

FIG. 2.

the appearance of the erythema there was rapid improvement in the sycosis, and by February 1st all evidence of disease had entirely disappeared. The mass of exuberant granulations referred to above had shrunken until it was almost on a level with the skin, and was covered with healthy epidermis. The condition since February 1st is shown in the accompanying photograph (Fig. 2). He has had no lesions since that date. The skin is smooth and soft, and healthy looking, but the hair has not yet reappeared.

65 Randolph Street.

A PLASTIC OPERATION FOR A NEW SCROTUM, WITH REPORT OF A CASE OF GANGRENE AND SLOUGH OF THE INTEGUMENT OVER THE EXTERNAL GENITALS.*

By Ramon Guitéras,

New York.

A. G. Age, twenty-five. Single. Laborer. Was admitted to my service at the City Hospital, May 7, 1900. He stated that he was well up to two years ago, when he contracted a urethritis that lasted up to five months before his date of entrance. Three months later, a swelling of the external genitals appeared, accompanied by pain and redness. The condition grew rapidly worse and the skin over the genitals became black in color, after which the skin dropped off, leaving the genital organs exposed. He said that during this time he had frequency of urination, but no other symptom, excepting pain and swelling, followed by the gangrenous sloughing just alluded to.

Examination.—The external genitals looked red and raw. The penis had no integument over its lower surface and sides, while on the dorsum it was uncovered from one inch behind the corona to the pubes. The scrotum was entirely absent and the testes were bare and drawn up towards the pubes closely, resembling two large cherries, and were covered with a sticky exudate. The line of slough was irregular.

Operation.—A plastic operation was performed, which consisted, first, in trimming the irregular edges caused by the slough, over the pubes, the sides of the thigh and the perineum, then dissecting two oval flaps about two and a half inches long and one and a half inches wide from either side above the pubes in the inguinal region, and two more of similar size from the inner side of the thighs in the region of the adductors as in Fig. I. These flaps were then brought down and sewn together, as is illustrated in Fig. II., covering the testes in a manner somewhat resembling the covering of an old-fashioned baseball. A few small grafts were then taken from the sides of the thighs and

* Read before the Harvard Medical Society of New York, on Saturday, January 25, 1902.

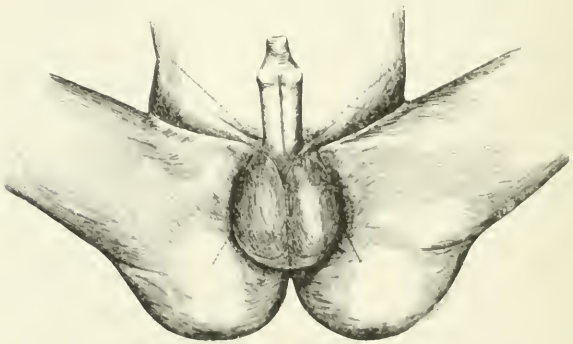
placed upon the raw surface of the penis. The new covering and the grafts held successfully, and, saving a slight leaking where the flaps came together in front of the scrotum and in the perineum, the re-

FIG. I.

covery was uneventful and the patient left the hospital with his external genitals intact.

This case was reported afterwards at the Academy of Medicine at

FIG. II.



the Genito-Urinary section, but at that time I had no details as to his previous condition. The patient had stated that his sickness had originated when working in Fishkill-on-the-Hudson. After extensive

correspondence with the physicians of that place, I finally obtained some information regarding his condition before he entered the hospital and I will quote the following from letters received from Dr. John W. Atwood and Dr. George H. Williams of Fishkill. Dr. Atwood wrote as follows: "The Italian concerning whom you have written was brought to my notice in a shanty in one of our brickyards. He was suffering from an enormously swollen scrotum, pain, and delirium. I placed him in the charge of Dr. Williams of the Fishkill Hospital." Dr. Williams wrote: "The Italian mentioned in your letter was referred to my service in the Fishkill Hospital by Dr. Atwood. There was an enormous enlargement of the external genitals, which were black in color, the scrotum being as large as the head of a baby six months old. I made an incision through the prepuce, together with twenty or thirty punctures into the engorged penis and laid freely open the tissues of the scrotum, after which I dressed the entire mass with a charcoal poultice. A sloughing process ensued that extended over three or four weeks and was associated with a number of abscesses on the sides of the thighs and legs. The patient's general condition was bad and supporting and tonic remedies were given internally. Six weeks after admission, the integument had entirely sloughed away from the organs. It was thought at the time that it was a case of extravasation of urine, but a catheter was never used, nor had he any difficulty in passing his urine after he came under my care."

It will thus be seen that, although we have learned the condition of the patient before he reached the City Hospital, not much light can be thrown upon the cause of the gangrene. It seemed to me that it must have been due to an extravasation of urine, although on entering the hospital he had no urinary leakage nor had he any when under the care of Dr. Williams. Of course, there are numerous other conditions which might give rise to gangrene, such as traumatism occurring in diabetic subjects; but in this case there was no diabetes. I have also seen gangrene of the scrotum in patients suffering from alcoholism associated with nephritis or tuberculosis—none of which factors were here present. Cases have also come under my care of phagadenic chancroid, in which a great part of the external genitals were gangrenous, but in such cases the process was more extensive, and a part of the deeper tissues were involved as well. I remember a case of phagedæna in a woman, in which the process lasted but two weeks, and yet both her external and internal genitals and peritoneum were involved, and the patient died of a gangrenous peritonitis. I have also seen cases of gangrene of the scrotum associated with inflammation of Cowper's glands, in which cases the perineum was ex-

tensively involved, but I have never seen cases of gangrene corresponding exactly to this one excepting those due to extravasation of urine.

The report of this case has a special interest to surgeons and more particularly to those living in the tropics, on account of a disease quite prevalent there, namely, elephantiasis of the external genitals. This condition is quite prevalent in the West Indies and Windward Islands, and it has been my privilege to have seen two such cases operated upon by removing the entire integument from the penis and scrotum, after which the surfaces were allowed to gradually heal by granulations and by skin extensions from the tissues of the thighs and pubes.

It will be seen that such a covering in inferior to the plastic one which I have here described; for after healing by the granulation process the tissues are so bound together that they are as held in a vise and their mobility and elasticity are seriously interfered with.

75 West Fifty-fifth street, New York.

TWO CASES OF RARE BROMIDE ERUPTION.

By T. F. WALLHAUSER, M.D.,

Visiting Physician, Hospital of St. Barnabas. Dermatologist, Newark City Dispensary.

MISS R. H., age fifteen, native of Austria, was in good health until May, 1895, when she received a slight injury to her right index finger, from which time her illness dates. She became melancholy; this condition being followed by violent fits of hysteria, for which she received bromide of potash in ten-grain doses every three hours. The eruption located on both lower extremities appeared about the third week of treatment as small vesico-papules, oozing and drying in yellowish green crusts surrounded by a zone of inflammatory redness. The papules were disseminated and grouped, running together in places to form large patches. The crusts were very characteristic, yellowish green in color; in thickness varying from $\frac{1}{16}$ to $\frac{1}{4}$ inch, irregularly circular in outline. The surface was traversed by deep sulcated lines, especially marked where patches formed. On removal of the crusts which were firmly adherent, there

presented numerous bleeding points corresponding to the papillæ, which were greatly hypertrophied.

Case I.

Case II.—Mrs. P., age thirty-six; has been subject to attacks of epilepsy for several years, for which she has been taking a proprietary

medicine. The eruption appeared about one year after beginning this treatment. She was treated by her family physician about six months, when she came under my observation. The lesion, which is extremely painful, is located on the lower extremity below the knee, and involves almost its entire circumference. It presents numerous fungating masses, limited to the border. The central portion of the lesion is pigmented and composed of numerous smooth rounded papules, mark-

CASE II

ing the site of previously existing fungoid masses. On the outer edge of the border and immediately outlying are numerous superficial vesicular and pustular lesions in various stages of formation, which mark the character of the formation of the patch. They begin as small pin-point vesicles, generally around hair follicles, and enlarge to about the size of a split pea or more, becoming purulent as they advance. On rupturing the enlarged papillæ are seen, which continue to enlarge, taking on the character of a granuloma. This process is continued for a period of from four to six weeks, when resolution begins, as a shrinking of the fungoid masses. The epidermis finally

covers the enlarged papillæ, forming the papules seen in the center of the patch. In some portions of the lesion these papules have entirely disappeared, leaving the skin smooth and shiny.

In looking up the literature on this subject, I was unable to find a case which would correspond in clinical description with either of the above cases, although I feel that they belong to the class of cases described by Cholmely, Sequin, Amidon, and others. Described under the various titles: "Confluent Acne," "Ulcus Elevatum," "Epithelial Ulcer," etc., the primary lesion in all these cases consisting of a vesicle forming a pustule with hypertrophy of the papillæ. The difference consists mainly in the clinical picture, which varies according to the predominence of any of these three conditions. Case II. must be considered as instructive from a clinical standpoint, on account of the opportunity afforded in observing the growth of the lesion by peripheral extension, which continued some time after the bromide was discontinued.

The treatment consisted in keeping the lesions bathed in Ol. Lini. and Aq. Calcis, equal parts, applied on sheet lint, which aided in the removal of the crusts and relieved the pain. Case I. recovered in seven weeks, Case II. in ten weeks, after the bromide was discontinued.

47 New Street.

Society Transactions.

FRENCH SOCIETY OF GENITO-URINARY SURGERY.

FIFTH SESSION.

(*Annales des Mal. d. Org. Génito-Urin.*, 1901, p. 1347.)
(Continuation.)

Sterility in Double Gonorrhoeal Epididymitis.—DR. PAUL DELBET.

There is a prejudice too widely spread that double gonorrheal epididymitis brings with it complete sterility. In truth, sterility is frequent, but we must not lose sight of the fact that it is, more frequently than not, easily curable.

In certain cases the marriage of men previously affected with double epididymitis remains sterile because the man has continued to have an imperceptible drop, perhaps without gonococci being apparent, and he has infected the woman shortly after marriage. It is then the woman who should receive attention, as the author has already observed in two instances of this kind.

In other cases it may be indeed the man who is affected, but the fact is rare. Of the cases seen by the author, not one of them has he ever found to be sterile. This is due, in his opinion, to the fact that these were patients whom he had completely cured by irrigations of a chronic urethritis, which was provocative of this sterility. According to his opinion, true sterility occurs only after double epididymitis with enormous swelling, intense pain, in the beginning of the infection, in these cases veritably hyper-acute.

Urethrorrhagia of Hepatic Origin.—DR. NOGUÈS reports an observation of urethrorrhagia anterior occurring in a man fifty-four years old, the subject of hypertrophic cirrhosis with chronic icterus (Hanot's disease). The patient, it is true, had some previous urinary trouble; in particular a vesical infection running back several years, but the canal was perfectly healthy. Moreover the conditions under which these hemorrhages were produced show that they had their source in the anterior urethra only, without participation on the part of the posterior urethra or the bladder. The bleeding was not severe, but a true abundant hemorrhage. Injections of antipyrine in 3 per cent. solution made an excellent hemostatic.

The hepatic origin of this hemorrhage was evident by the appearance at times of similar accidents from other mucous membranes (epistaxis, hematorrhagia, hemophysis, hemorrhage from the intestines purpura). The patient died within three months after the occurrence.

New Method of Internal Urethrotomy, without Catheter a demeure; Rapid Dilatation.—DR. H. REYNÈS regards as exaggerated the fear of infection or hemorrhage after internal urethrotomy; he believes with DR. VILLENEUVE that after this operation, the catheter *à demeure* can be dispensed with. He employs the following technique, which he has adopted for two years: (1) antisepsis (he uses the sulphibenzoate of soda); (2) incision with the Maisonneuve

neuve; (3) introduction of an ordinary catheter, 17 or 18, and lavage of the bladder with a weak nitrate solution; irrigation of the urethra on withdrawing the catheter; (4) the following *séance* he dilates with the Beniqué sounds, 17, 18, 19, 20, 21; (5) the application of an antiseptic dressing to the penis and glans. During the day the patient urinates without catheter, and applies fresh bandage after each urination. In the evening and day following lavage of urethra and progressive dilatation with sounds; in three or five days, sounds of No. 24 to 29 are used. After this the patient is seen at intervals for examination and dilatation.

Dr. Nicolich has done 500 urethrotomies, and is of an entirely different opinion. He has attempted to do away with the catheter *à demeure*, but with bad results. For the prevention of fever he leaves a catheter *à demeure;* this assures of absence of fever and chills, while the withdrawal leads to this occurrence.

Dr. Tédenat has done about 650 urethrotomies without a death and without accident. He leaves a catheter in place for twenty-four to forty-eight hours at the most. He makes his incision with the instrument of Civiale. In the thesis of Grégori, we may see that internal urethrotomy is regarded as a dangerous procedure; it is the catheter *à demeure* which has changed this prognosis.

Dr. Escat saw Horteloup attempt for a year to do away with the catheter *à demeure;* accidents occurred. Patients could not dispense with the catheter *à demeure*, even when their urine was aseptic. Horteloup left the catheter *à demeure* for four or five days. Dr. Escat has seen patients die, because of failure to use the catheter *à demeure*, while with its use internal urethrotomy is always benign. As to immediate dilatation, already presented by Reybard, since forgotten, it had in his hands deplorable results. Slow dilatation besides gives better remote results.

Dr. Poussón agreed with the latter speakers as to the necessity for the catheter *à demeure*. He never failed to have recourse to it himself, and to it he attributed the good results he had had in 400 to 500 cases. He disapproved of intra-urethral maneuvres after section. Internal urethrotomy was one of the most benign operations of surgery, but only when practised under the most painstaking minutiæ. These precautions have been formulated by the chief of the Necker School, and it is well to recall them here.

Dr. Loumeau also spoke in favor of the catheter *à demeure* following internal urethrotomy as a simple procedure, and one assuring security against accidents. He spoke as one who had attempted the giving up of its use, and while, especially in aseptic cases, it could be done successfully, yet every now and then without its use you will have a nasty accident entirely avoidable through its use. He also was against immediate dilatation following urethrotomy.

Dr. Le Dentu had also tried latterly to do away with the catheter. He had not had a death in the healthy individual. When he did not use the catheter he would have a temperature of 38° to 38.5 C. on the second day. While there never was an elevation of temperature with the employment of the catheter. It should not be left in over thirty-eight to forty hours, or there would be reappearance of fever. But in the cases of an infected patient it is better to leave it in a longer time. He did not do immediate dilatation, such procedures were dangerous.

DR. NOGUÉS believed that the passage of urine between catheter and canal would not take place in the case of a catheter properly placed.

DR. FRANK recommends, in case of hemorrhage, supra-renal extract. With the endoscope we can note the anemia of the urethra after its application.

DR. REYNÈS wished to reserve his reply until after he had had a greater experience. There was no use in comparing his method by aseptic measures with the results of the pre-antiseptic period and the use of non-sterilized sounds. Done aseptically, his method presented no sort of danger.

DR. ALBARRAN.—We may often do a urethrotomy without accident; but formidable accidents have been noted in patients subjected to urethrotomy and not provided with a catheter *à demeure*.

Remote Results of Internal Urethrotomy.—DR. P. GUILLON.—This work was done at the clinic of Dr. Desnos; it covers ten years, during which 248 internal urethrotomies were done without a death. More than 150 have been seen regularly since. In almost all these cases unwilling to undergo subsequent dilatation, a recurrence more or less rapid has been the rule. For the great majority of cases, however, even at the end of ten years, the cure has been permanent, that is the permanent maintenance of the calibre regained has been the rule.

These results are to be attributed rather to the subsequent dilatation than to the method of urethrotomy employed, each one of which has its precise indications.

They always sought systematically the highest dilatation possible for each canal without being able to fix upon a determined size, though 60 Benique was almost always attained.

The systematic examination of every case with the bougie á boule was never neglected in order to assume the attainment of the perfect suppleness and regularity of the walls. The importance of this is insisted upon.

The majority of these patients returned regularly for dilatation, above all for the control examination of their canals, at first at close intervals, afterwards at increasing intervals up to a year.

It is in this manner that Dr. Desnos has obtained durable recoveries after internal urethrotomy, a safe operation in his hands, but one always regarded by him merely as a part of the process of dilatation.

Meatotomy with the Galvano-Cautery.—DR. GENOUVILLE.—It is often necessary to practise meatotomy, in order to obtain the highest possible dilatation with the Bénique instruments. Ordinarily it is done by the insertion and see-saw movement with the bistoury; he proposes section of the meatus with the galvano-cautery it being bloodless, less painful, and producing a wound less liable to infection. This last is especially important in the case of the subject of an acute gonorrhea, when the meatus is too narrow to allow free drainage of the secretion from the meatus and a bar to irrigations. In such a case the bloody operation during an acute gonorrhea may be a veritable danger.

The following is the technique: antisepsis and cocainization, separation of the lips with a special speculum, or a pair of hemostatic forceps; then dividing at the meatus with a small galvanic knife. The section is almost bloodless, the sequelæ *nil;* a small tampon of cotton beneath the prepuce suffices for a dressing, afterwards dilatation is easy. He has seen a patient nine months after such an operation in whom the passage of a large sized instrument was easy.

DR. FRANK prefers meatotomy to avoid hemorrhage; he inserts into the

canal a small metal tube filled with glutol, which is expelled at the first act of urination.

Inflammatory Stricture of the Urethra in Women.—DR. GENOUVILLE.—A woman, forty-six years old, having had a puerperal metritis ten years before, and some time after a urethritis, came to consult for an unnatural frequency of urination and difficulty of urination (requiring considerable initial effort to start the stream). The urethra was strictured; it presented two large bands which allowed 22 olive-tipped bougie to pass. Dilatation with Bénique sounds, disappearance of the difficulty and the frequency of urination.

This observation shows once more how in women a slight amount of stricture may impede urination, it seems to be due to the relative feebleness of the musculature of the feminine bladder.

Treatment of Incontinence of Urine by Epidural Injections.—DRS. ALBARRAN and CATHELIN.—Fifteen cases, very varied, were treated by epidural injections of serum (15 to 20 cubic centimetres to an injection) or of cocaine 2 per cent. (1 c.c. to an injection). In general two or three injections were made a day's interval apart, and according to the effect obtained they were repeated more or less often; in the majority of cases favorable results were obtained with the first injections. Out of the 15 cases there were only 2 complete failures in the case of urinary tuberculosis; all the others were either cured or materially improved.

The cases were thus divided:

Five cases of nocturnal incontinence in children, of which there were immediate cures from the injections of serum; 2 showed marked improvement after two or three injections, of which the last were with cocaine, 5 milligrammes.

One case of nocturnal incontinence in a neuropathic adult, markedly and rapidly improved.

Two cases of incontinence, the origin of which was undetermined; the first was a case of hemiplegic cured by a single injection, made by Dr. Toupet; the second case was that of a paraplegic with diurnal and nocturnal incontinence lasting twenty months; the injections caused cessation of the incontinence by day, but the nocturnal incontinence persisted.

Two cases of false incontinence (urination almost continuous) and one case of complete incontinence in old women aged 68, 72, and 78 respectively; these patients had patulous urethræ; two were definitely cured, and one had alternating continence and incontinence.

One case was a patient having complete incontinence for eighteen months from vesico-prostatic calculus; following a single injection, the patient remained continent up to the time of his operation, twelve days later.

Three cases had complete incontinence from tuberculosis of the urinary tract. The first patient, since dead, was a case of advanced cachexia, with renal and vesical tuberculosis; failure. The second case with tubercular kidney and bladder was a failure, but after nephrectomy the incontinence disappeared. The third case with genital and vesical tuberculosis had been incontinent day and night for eight months; he remained continent after the injections now for over forty days.

These remarkable results, obtained in cases of such diversity, prove that in the pathogenesis of incontinence of urine, though apparently so dissimilar, there is a common factor: inhibition of the sphincter.

Without being able yet to speak of the value of this method of treatment,

absolutely safe, the authors believe that new trials are justified by the encouraging results obtained.

Purulent and Tuberculous Urines.—DR. NOGUÈS.—Dr. Noguès completes the communication which he made two years before on the same subject, and gives the results of the observations made since that period. There is a certain number of cases of purulent urine in which the most careful search fails to reveal the tubercle bacillus. Clinically, they possess the nature of tuberculosis, and it is the experimental verification of this fact long since maintained by Professor Guyon that Dr. Nogues has furnished by the aid of inoculations upon animals.

Certain precautions and the observance of certain points of technique have lowered the proportion of urines surely tuberculous in which, however, the microscopic examination does not aid us in finding the bacillus. Nevertheless in spite of all precautions there remains a certain number of cases where the direct examination still shows a negative result. In 37 cases in which microscopically neither the bacillus of tuberculosis nor any other micro-organism could be found, inoculations were made upon animals, of this number 14 still gave negative results, while 23 showed positive presence of tuberculosis.

Abscess and Urinary Fistulæ.—DRS. HERESCO and S. GALATZI.—Altogether out of 13 cases of abscess and urinary fistula, the authors report success in 12 in which the mode of procedure differed widely one from the other. There is no single treatment to recommend for abscess and urinary fistula. Each case presents particular conditions which necessitate a different technique.

They lay stress on the advantages of the procedure which consists of suturing the urethral walls where the urethral sclerosis is limited, and leaving open the rest of perineal tissues.

Sterilization of Catheters.—DR. FRANK has continued his examinations of silk woven catheters and has shown that now the manufacture of silk instruments does not vary greatly from those formerly made in Paris.

As to the sterilization and the resistance of these instruments to chemical agents, he has made his experiments with steam (Kutner's apparatus), with the sulphate of ammonia (Einesghk) and with ordinary water.

The catheters sustained very well the sulphate of ammonia, 10 per cent., the steam not so well, and ordinary water very badly. The best method is sterilization with boric aldehyde (Trioxymethelene) applied by Frank in Germany and by Janet in Paris. Frank uses the apparatus constructed by Romanès. He has made bacteriological experiments and has found that we can secure exact sterilization in the case of the narrow channels in the operating cystoscope in ten minutes.

Spermatorrhoea and Its Treatment by Electricity.—DR. D. COURTADE.—Electricity acts best in those cases of spermatorrhœa of neurasthenic origin. It should not be employed in cases with local lesion until these have been cured.

In cases of spermatorrhœa with organic affection of the nervous system electricity may be useful in the beginning.

Extirpation of the Vas Deferens and Seminal Vesicles.—DR. LE DENTU.—In this operation the most important points are free section of the anterior and posterior walls of the inguinal canal, the isolation of the vas without rupturing it, without wounding the other elements of the cord and above all without tearing the peritoneum; the following of the vas up to the ejaculatory duct, the

separation of the vesicle without grave hemorrhage and without perforation of the peritoneum or of the bladder. The rules laid down by Baudet and Duval on this subject are very precise. As to the epigastric artery, it may be divided with its veins, between two ligatures. The separation of the vas is rendered easy by leaving all the fatty tissue in front and going down to the peritoneum, the vascular hilum of the vesicle may thus be avoided, being in front and to the outside. The hilum is indicated by an aponeurotic bridle extending vertically; hemostasis is made by catching the pedicle between forceps, then placing a ligature around the ejaculatory duct.

This operation is not always easy to execute. In cases where the vas is adherent to the peritoneum, its separation is to be abandoned.

Rectal touch is valuable to ascertain the condition of the vesicle.

In cases of chronic inflammation with adhesions and suppuration, we must abandon the extirpation by the ilio-inguinal route which responds only to simple cases; for the others the author would give preference to the perineal route.

The impossibility of being able to determine the extent of the lesions should make the surgeon very radical.

Extirpation is not a grave operation, but the repair of the inguinal canal should be carefully made. As to the vesicles a slight tuberculous lesion is not always an indication.

In the cases of vesicular lesions with lesion of the testis and epididymis, everything should be removed, even where the lesions are medium. A bad general condition is a contra-indication.

New Procedure in the Diagnosis of Chronic Prostatitis.—DR. DORST.

Diagnosis and Treatment of Prostatic Abscess in Hypertrophy of the Prostate.—DR. MINET.—The diagnosis of these abscesses may be very difficult: (1) In the latent form, which gives us functional signs and exposes the patient to very grave periprostatic phlegmon; (2) in those forms in which the disturbance is the same as those observed in prostatics without abscess; as complete acute retention or incontinence from overflow; the co-existence of a stricture of the urethra may complicate the examination; (3) when there is an intercurrent disease of other organs.

These difficulties render it necessary that the rectal examination should be made in all prostatic cases. Attention should be particularly directed to the prostate when fever is present, whether a suppurating epididymitis is present or not, or if an intermittent blenorrhea or pyuria exists.

Rectal touch may at times give insufficient information; it may make us think an abscess exists when it does not; or a central abscess may be overlooked. If there is distention of the *bas-fond,* examination should be made if possible after evacuation.

Periprostatic lesions may mask intraprostatic or other periprostatic collections.

Often we may be unable to diagnose with certainty an abscess before its spontaneous opening followed by the presence of a point of depressibility on rectal examination.

It is important to note that rectal touch in the case of periprostatic trouble does not always permit of exact determination of the extent of the lesions, often much more extensive than would be believed. Evacuation by rectal incision should for this reason be rejected.

Origin of Certain Vesical Tumors.—DR. MOTZ.—The extreme rarity of carcinoma of the bladder in women and its frequency in men, points to an extra-

vesical origin of these tumors. In making the histological examination of 38 vesical tumors in men, the author has established the fact that in 28 cases the tumor was prostato-vesical. The results explain the recurrence observed so often in vesical tumors, and they indicate the necessity of making a good examination of the prostate before surgical intervention, and also point to the necessity of making an extirpation of the prostate where it is proposed to make total extirpation of the bladder.

Radical Cure of Hypertrophy of the Prostate.—DR. ALBARRAN.—The author is convinced that in hypertrophy of the prostate the loss of vesical contractility of the bladder is secondary to the glandular lesions. He believes moreover that even in inveterate cases, the secondary sclerosis of the bladder plays but slight *rôle* in the lessening of the power of urination; if the patients experience difficulty of urination or have complete retention, it is because the mechanical obstacle caused by the prostate opposes it, and in part also because the contractility of the bladder is inhibited. Guided by these ideas he has removed the prostate as completely as possible, without injuring the sphincter. A year and a half ago he operated upon two patients by imperfect methods; one carried a fistula four months; the other recovered and remains cured.

Before six months ago he had operated upon fourteen patients, and the observations are reported in a thesis of an interne, Dr. Petit; there was only one death; all the patients, when the treatment is finished, are cured; those still under treatment empty the bladder spontaneously.

Gravity of the Operation.—All his patients were infected; their mean age was 63 years (57 the youngest, 73 the oldest); three had pyelonephritis, several were in a bad general condition, many presented serious operative difficulties. Under these conditions he only had one death, and the post-operative conditions were always simple, except in one case whose perineal wound closed too soon, who presented the phenomena of infection.

Therapeutic Results.—Of the fourteen, one left the hospital before closure of the wound and he has been unable to obtain news of him.

Two recently operated upon still have a catheter; both are doing well.

Three, still under treatment in the hospital, empty their bladder completely, but still lose some urine by the perineum; these were recently operated upon.

Eight are cured; they empty the bladder completely and spontaneously; the urine has become clear, their general condition good, and since the operation have not used a catheter. The oldest case operated upon dates from April; he had had complete retention for eight months; he remains cured.

Of the eleven operated whose treatment is finished or practically so, four had had complete chronic retention, dating from eight months to five years; two had a complete retention recurring during the previous fifteen and seventeen days; five had chronic incomplete retention of 150 to 500 grammes, necessitating the use of the catheter several times a day.

The absence of mortality, the simplicity of the post-operative condition, the therapeutic results surpassed the author's hopes. He believes that perineal prostatectomy is indicated in all prostatics except when there are contra-indications due to diffuse local suppuration, to grave lesions, to bad general condition, or too advanced an age, when catheterization is well tolerated.

DR. PROUST.—At the present time prostatectomy is becoming more and more the customary procedure and will become more and more so. It is important to determine upon the precise details of this operation. Dr. Proust has formulated

the details upon two occasions. The first time two years ago (Gossert and Proust, Annales Gén.-Urin.), and recently in some recent work. At this time making a plea for prostatectomy for hypertrophy he has formulated the following procedure: Prerectal incision; separation of rectum and prostate. The posterior surface of the prostate is thus exposed, covered by the prostato-perineal aponeurosis. In order to bring the prostate into convenient reach, he has recourse to the following maneuver. He introduces through an incision made through the membranous urethra a sound with the end bent as a right angle; after introduction the instrument is turned 180°, so that the beak of the sound points toward the *bos-fond;* by drawing the instrument towards him the operator can bring the prostate well under control. Then enucleation of the prostate. It is then that hemisection of the prostate may be done, so important for the success of the operation; then we can proceed to the dissection of each of the lobes; after their enucleation and section the urethral wound remains to be sutured.

But if there are conditions well laid out for an operation, for example essential for the procedure as practised to-day by Dr. Albarran, the operation is done in a veritable pit. The latest researches of the author lead him to take a special position; an inverse perineal position or sacro-vertical, which permits the retraction of the posterior border of the incision even back to the coccyx. He hopes that this improvement of the position, considerable in his opinion not only for operation upon the prostate but for removal of the rectum, vesico-vaginal fistula, etc., will be accepted and employed as were the details of Proust's first technique, such as hemisection of the prostate.

DR. LE FUR reported a case of prostatectomy by the perineal route in a patient 68 years old, affected for a long time with symptoms of hypertrophied prostate. At first incomplete retention, followed for the month before operation with complete retention, which a catheter *à demeure* could not modify. He described the method adopted in this particular case where the difficulty lay in the inequality of the lobes (the left lobe much larger than the right, and in its evolution toward the *bas-fond* and neck of the bladder formed such a mass that it was absolutely impossible to bring down the prostate into the wound, either by an instrument or by the finger inserted through the urethral wound into the bladder. The perineum being very thick created a new difficulty. Dr. le Fur decided to remove the large left lobe piece-meal; after removal the prostate was easily brought down to the level of the perineal wound. He advises this method under these conditions, leaving the extirpation of the smaller lobe for the last, as in this way the danger of wounding the urethra or bladder is avoided.

It is better not to make too large a wound in the urethra and not to incise the vesical neck, except where a median lobe exists (?), because a perineal urinary fistula may form more quickly. It is perhaps advantageous to replace the perineal drain by a catheter *à demeure* or a Pezzer catheter through the perineal wound, as in his case the drain caused painful contractions of the vesical neck and slight terminal hemorrhages. The drain was left in 5 days, then replaced by a catheter *à demeure* which was well borne. At the end of eight days the perineal wound was closed by two tiers; at a single moment the dressing took on a bad odor, probably from a small slough in the perineal wound, which quickly yielded to a lavage of silver nitrate solution (1-500). Up to the eighth day there had not been the slightest shock from the operation, the patient had gained, the urine became clear. After removal of the perineal drain the patient remained without a catheter *à demeure* for some time and was able to urinate partly

through the wound and partly through the pendulous urethra. The contractility of the bladder returned and the patient completely emptied the viscus.

DR. TÉDENAT had operated upon 4 cases of hypertrophy of the prostate in 1898 and published his results in 1899. He avowed his method of technique with some hesitation. Once he tried to crowd down the prostate into the perineum through a supra-pubic opening. Another time he had recourse to a large lithotrite introduced by the urethra into the bladder, and like Dr. Proust he was pleased with the way which the beak of this instrument controlled the prostate. As to the position given to the patient he did not go so far as to make him assume the sacro-vertical position as indicated by Dr. Proust, but he always elevated the pelvis as much as possible for this operation. Finally he avoided, wrongly without doubt, opening the urethra and sought to remove the hypertrophied tissue as well as possible. He repeated that he had no fixed technique. One of his patients died in three months. The other three remained cured; as for any residual urine, it was insignificant.

DR. POUSSON.—Can the operation so brilliantly applied by Dr. Albarran be applied to all cases of hypertrophied prostate? He did not think so. There was such a multitudinous variety of these cases, he thought, that outside of operations upon the external genitals we should preserve all the other methods. The Bottini operation, suprapubic prostatectomy are very much in favor with surgeons of other nations. And not to speak of suprapubic prostatectomy he asked Dr. Albarran whether he thought his procedure of perineal extirpation was applicable to cases where the median lobe took predominance in the hypertrophy, or in those cases, sufficiently frequent, in which the median lobe sprang up into the vesical cavity, in a manner analogous to the projection of the cervix uteri into the vagina. For his part he believed that these cases were best relieved by the suprapubic route, but these cases aside, he thought that the perineal prostatectomy as conceived by Dr. Albarran had a brilliant future.

DR. ALBARRAN spoke in reply. Dr. Proust had indicated two modifications which he had added to the technique of prostatectomy, which he has described two years before. He recommended the bent sound introduced by urethra into the bladder to depress the prostate, and the utility which the sacro-vertical position gave to the patient. As to the sound, Dr. Tédenat had said he also had already utilized this same idea. For his own part, at different times, he had used his own catheter *coudé* for the same purpose. As to the sacro-vertical position, he believed it to be very advantageous and he agreed that the nearer the pelvis was brought to the vertical plane the easier it was for the extirpation of the

In a few words he would tell how he operated:

He makes a bi-ischiatic prerectal incision, simple without liberating cuts. This has always sufficed. He immediately hunts for the bulb of the membranous urethra. He thus reaches the prostate and then separates the rectum, which he draws back with a protecting retractor. M. Collin has constructed for him recently an apparatus which allows fixation, so to speak, of this retractor to the patient's pelvis, and by this automatic device he can do away with one assistant. Up to this moment he has not touched the levator ani muscles. He frees these with scissor cuts if they hinder him, but he could say that more often he could dispense with this procedure. He then cut into the capsule of the prostate with a bistoury as far as possible. For he believes it necessary to make a subcapsular enucleation of the prostate after the manner of Nicoll. The extra capsular ex-

tirpations were far more dangerous. Upon this point he differed essentially from Dr. Proust.

It is then that he makes, as Dr. Proust advises, hemi-section of the prostate. This hemi-section takes in the inferior wall of the urethra behind the membranous sphincter and is carried up to the neighborhood of the bladder neck but does not involve it. Liberating, then, each lobe from the corresponding urethral lip, he extirpates the anterior suburethral portion of each lobe. Then he can, having done this, insert his index finger into the bladder, depress the *bas-fond* and extirpate the remaining portions of the prostate. The index finger thus inserted is a valuable guide as much for recognizing the thickness of the prostate remaining as for protecting the bladder wall. In this fashion, thanks to the previous separation of the capsule and to the easy exploration of the bladder with the finger, he can be sure of not having torn the prostatic cage and of not having caused destruction which could become grave.

Thanks to these precautions he has had only insignificant hemorrhage. This is so true that he has never been obliged to place ligatures, while he had never failed at this point to put on hemostatic forceps as often as he had attempted extra-capsular resection of the prostate.

In reply to Dr. Pousson, he would say that perineal prostatectomy did permit removal of the median lobe. He had always been able to extirpate it in his operations, whether by previous section of the vesical mucous membrane as was done in suprapubic prostatectomy, or by depressing that lobe with the index finger. He had had recourse once to the first of these maneuvres and he had been able, moreover, to suture the vesical mucous membrane.

After this extirpation of the prostate, he sutured then the prostatic urethra, first excising the borders of the wound. Because we must not forget that the prostatic urethra is dilated in these cases of prostatic hypertrophy, it has become too large and its calibre should be diminished. But this urethral suture is partial, he leaves an aperture at the lower angle through which he passes a drain into the bladder. This perineal drainage of the bladder in the first few days following the operation is of prime importance. It is necessary to maintain it. If the patient of Le Fur suffered from a drain so placed, it was because it was badly placed, probably not pushed far enough into the bladder. Dr. Petit, his interne, took special charge of this in all the patients operated upon, and in not one case did the patient suffer from the drain.

He knew of the operations done by Tédenat four years ago and had referred to them in his report. Dr. Tédenat had retained this impression that perineal prostatectomy was a grave operation. This impression was also shared by the majority of surgeons. It is still the actual impression. Now he thought it was no longer necessary to hold this opinion, after the series of cases which he had reported. Not only had perineal prostatectomy not given the mortality but the results obtained had surpassed his hopes. In suppressing the prostate, we gave back its functions to the bladder, which it had apparently lost, and the patients were benefited from every point of view.

He did not wish to enlarge here upon the mechanism of this cure. Without doubt the removal of the prostatic obstacle should be taken as the cause. But he thought that another reason existed, a phenomenon of inhibition exercised by the operation. Moreover, prostatectomy does not have the monopoly of this inhibiting influence. The first prostatic upon whom he had operated, had formerly been in a state of complete retention and nevertheless he emptied his bladder

spontaneously the same day as the operation. He had seen in some of his cases the bladder previously apparently atonic recover its contractility very quickly.

He closed by saying whatever the mode of action of prostatectomy, it is the operation of choice in all cases of hypertrophy of the prostate and that it is the perineal route to which we should have recourse to extirpate the prostate and to gain the best conditions of technique and security.

The Bottini Operation in Prostatitis.—DR. CARLIER.—Before all the operations practised upon the testicles and cords to modify the situation in prostatics, and trusting in the results obtained by some surgeons by means of the galvano-cautery applied to the prostate, Dr. Carlier had operated upon eight cases by the Bottini method. According to the conformation of the hypertrophied prostate he had made one, two or three cuts, with the cutting blade heated to a point between red and white heat. Almost always the section was made behind in the median line, three times in the median line, together with bilateral cuts, but in no case, Dr. Carlier insists on this, was an anterior cut made into the vesical neck. The posterior urethra was always carefully disinfected, as well as the bladder, and this organ was immediately distended with air.

Only one patient received chloroform, five were anesthetized with bromide of ethyl, the last two had local anesthesia with cocaine. The latter method sufficed.

Of these eight cases, two were badly infected with renal complications, four slightly so, two cases only were aseptic. One of these cases was subjected twice to the operation, at a month's interval. The age varied from 57 to 68 years; contrary to the advice given by Bottini, Dr. Carlier always left in a catheter *à demeure* for four or five days following the operation. These nine operations passed without accident and without consecutive febrile reaction. In three patients there occurred a hemorrhage, otherwise without gravity.

Considered altogether the results obtained are more than mediocre. Two patients were operated upon too recently to take into account. Of the six others, one only has been benefited by the operation. This was a man 57 years old, who for two years had absolute retention. A first median section gave no relief, a second section made a month later comprised three cuts and he improved to the point that two months after the operation this patient used the catheter no longer, but the bladder held a residue of 100 grammes.

Four others of these patients urinated more easily than before the operation, but their residual urine being less than before is sufficiently important. One patient had nocturnal incontinence for weeks, but this stopped later.

For the rest he could say that there had been no deplorable accident and that the operation is easy to perform. He does not believe in the future of the Bottini, which he regards as an operation hardly surgical. In the fortunate cases it only momentarily relieves the obstacle to the passing of the urine, it does not hinder the ultimate development of the hypertrophy.

DR. DESNOS.—From the discussion one gets the idea of the necessity for an operation for hypertrophy; but in his opinion the procedure should vary with the form of the hypertrophy and he believes that he can formulate those which will be benefited by the galvano-cautery. The two primordial conditions of partial prostatectomy are found here, that is to say, those where the obstacle projects into the bladder near the neck, whatever the volume of the prostate, on the one hand, and on the other the conservation of the more or less total of the contractility of the bladder. In his twelve cases operated upon his results were excellent in six, incomplete in the others. The difficulties of catheterization constitute an indication of the first order, and in all the passage of the catheter is

rendered easier. The condition of retention was improved in all his cases, and six completely emptied their bladders, after a variable time. In the others the amount of retention was lessened.

Among the contraindications the first is infection; we should not operate upon the infected patient except with the greatest circumspection and never during an acute attack; cystites have been observed and prostatites have presented a certain gravity; he has even had a small abscess of the prostate. There was no death. This of which we should be forewarned is the tardiness with which the results are produced, apart from the greater ease of using the catheter which is usually immediately; as to the inflammatory complications they present an analogous progression and diminish slowly.

He has modified the galvano-cautery of Freudenberg in doing away with the endless screw which permits the development of useless force and even harmful, because it permits the blade to jump the prostate without incising it. He has replaced this with a rack with large teeth moved by means of wheel and pinion which transmits to the hand the slightest sensation of resistance.

Psuedo-Membranous Cystitis, Supra-pubic Operation.—Dr. Escut describes the case of a patient affected with this singular affection described by Guyon and Girard in 1887. The study of it has been again undertaken since by Grousset, pupil of Rochet. (These de Lyon, 1898.) The patient was sent to the author in June, 1900, suffering from vesical trouble for the previous fifteen months and coming on after eight days of absolute constipation. There were no genito-urinary antecedents; nor did the genital apparatus show any lesion. Urination was not increased in frequency, the bladder was always well emptied and its capacity normal. The urine was very cloudy, with a repulsive fetid odor, it was ammoniacal and deposited on standing an immense amount of whitish débris, the largest masses 4-5 millimeters. The débris was incrusted with calcareous deposit, some of the débris not incrusted floated like pellicles of wax. The author thought the débris was due to decomposing papillomatous growths, the microscopic examination only revealed dense strata of pavement cells. There was no trace of villosities. The urine was not purulent, the cloudiness was due to the epitheliorrhea and a microbic flora of various organisms. Cystoscopic examination showed a bladder surface covered with whitish floating masses but little raised.

Urotropin and irrigations with boric acid solutions gave considerable relief as the putrefaction and phosphatic precipitate and ammoniacal condition ceased, but reappeared when treatment was omitted. After a year of palliative treatment a suprapubic cystotomy was done. The bladder was very large, of the infantile type ascending high above the symphysis. On incising the bladder, the entire mucous membrane covering the bladder was of a silvery whiteness, 3 millimetres in thickness. An energetic rubbing removed this, leaving a mucosa with a large venous plexus and ecchymotic placques. The epithelium was friable, the vesical wall thick, the submucosa very supple; no ulceration and no induration. After this rubbing off of the epithelial rind and curretting, the entire surface was subjected to the thermo-cautery. Prolonged drainage. After its removal there was a rebellious fistula for four months. It has for the past month closed solidly, the catheter was removed only ten days before. The urine, clear while the catheter remained in place, became slightly cloudy and began to have an odor, and carries a fine débris. The result is doubtful.

Precocious Gonnorrhœal Infection of the Bladder.—Dr. Guillon described the case of a patient who for three days had considerable terminal hematuria

(40 grammes) at the end of each urination, absolutely without pain or frequency. With the hematuria appeared a slight discharge. The patient was not greatly disturbed with his condition because there was no pain. Microscopic examination showed numerous colonies of gonococci, intra- and extra-cellular.

The hematuria quickly yielded to intravesical instillation of protargol and the urethritis yielded to anterior treatment.

DR. LE FUR thought the case resembled rather a case of simple ulceration of the bladder due to gonococcic invasion; the absence of frequency and pain, the profuse hematuria seemed to confirm this.

The presence of gonococcus in the urine did not contradict this diagnosis. He recalled the researches he himself had made (1901) upon this subject. These ulcerations are in other respects similar to ulceration of the stomach, intestine and of the mucous membrane of the biliary passages; now it is admitted at the present time that all simple ulcers are of infectious origin due to different micro-organism; *simple* ulceration here means that it does not arise from any known pathological process (tuberculosis, neoplasm, chronic cystitis, foreign body, calculus, etc.).

DR. POUSSON thought that at the present moment when we were studying on all sides the procedures for the best method of the management of prostatic hypertrophy to remedy the dysuria in old men, it might be interesting to draw attention to another variety of obstacle which at all ages though exceptionally was a hindrance to urination. This was the existence of a valve developed at the vesical neck. Without according to this vicious condition either the frequency or importance which Mercier attributed to it, its actual existence could not be denied. He had observed two cases in the past year. The first was a young man of 25, who for a long time had presented phenomena of painful urination which had given rise to the suspicion of an epiprostatic calculus, the more so as it was noted that in front of the neck there was given a sensation of gravel to instruments which were stopped at that point. The bladder was opened and the valve found and resected, and the patient cured. The second was a man 50 who had been treated for several years for urinary difficulty thought to be due to prostatic trouble. After examination Pousson was convinced that the trouble was due to a very fine valve springing from the prostate at the vesical neck. This was found and resected after opening the bladder. The patient recovered full power of urination.

DR. LOUMEAU had operated some years ago upon an old prostatic with large calculus. The suprapubic opening revealed a fan-shaped valve on the inferior surface at the neck, thin and soft and not resembling in any way hypertrophy of the median lobe. Fearing to complicate the operation, Dr. Loumeau did not interfere with this valve and the patient recovered normally. Eight years after this a new suprapubic cut was made for another large calculus, and although at this time he sought for the valve, no traces of it were found.

DR. CARLIER has seen three cases of valve at the bladder neck.

Report of a Case of Papilloma of the Bladder Operated Upon through the Cystoscope by Dr. Nitze.—DR. JANET, in the month of May, 1901, was consulted by a woman 65 years old for hemorrhages into the bladder, which she had had repeatedly for twelve months. Examination revealed the presence of a vesical papilloma the size of a nut, situated at the posterior border of the trigone. It was composed of two portions, a rounded projection pedunculated with a vermiform excrescence floating in the bladder fluid. The rest of the bladder was healthy. The author gave his reason for prefering in this case operation through

the cystoscope and called Dr. Nitze to Paris. The tumor was removed in two or three séances.

The sequel to the operation was simple, only slight hemorrhage, the patient was not confined to the bed and could walk out each day.

He had a few days before examined her through the cystoscope and the only trace of the operation was a yellow linear cicatrix scarcely visible.

Total Leucoplasia of the Bladder.—DR. RAVASINI reported a case.

Note upon Continuous Irrigation of the Bladder after Supra-pubic Cystotomy by Means of Continuous Installation.—DR. ESCUT described a new method of continuous instillation of an aseptic fluid drop by drop through the bladder in place of continuous irrigation, without distending the bladder, and regards it as a successful means of procedure in such cases.

Vesico-Rectal Fistula in Man Due to Calculus.—DR. CARLIER had occasion to operate for a large vesical calculus in a patient of 34 who since he was 7 years old had carried a recto-vesical fistula. The fistula had been caused by the expulsion of a small calculus from the bladder into the rectum. The fistula had never closed and the patient lost three-fourths of his urine by the rectum. It is interesting to note that the bladder and kidneys had borne this communication with the rectum perfectly for so long a time. The opening was large enough to admit the tip of the index finger and the patient frequently passed small masses of feces through the urethra. The urine was cloudy and contained the coli bacillus, but in moderate quantity.

Contribution to the Physiology and Pathology of Incision and Extirpation of the Kidney.—DR. POUSSON.—We know from the experiments and clinics of Professors Guyon and Albarran that the state of tension of the kidney modifies the secretion in quality and quantity, and that incision of the renal parenchyma causes cessation of the tension, and restores the urinary tension.

These same authors have shown, on the other hand, all that we have a right to expect from nephrotomy in surgical affections of the kidney which raise the internal tension: Anuria, neonephrosis and pyonephrosis. Thinking that by reason of the vascular alterations predominating in chronic nephrites the circulatory apparatus is profoundly modified and exposes the parenchyma to incessant variation of tension, Dr. Pousson was led to attribute the disturbances of urinary secretion in cases of Brights to an excess of tension and to combat them by nephrostomy.

He has done the operation in cases of parenchymatous nephritis, interstitial and mixed. At the time of intervention he has been able to verify the reality of intrarenal hypertension, for the kidney has always appeared tense, tumefied, of a red brown coloration, also after section of the capsule the parenchyma bulges out and the kidney wound bleeds profusely.

In all his cases the author only operated upon a single kidney, guided in his choice by certain vague indications causing him to suspect a unilateral nephritis or that one was the predominating side, such as spontaneous or provoked pain in one of the lumbar regions, edema plainly unilateral or more marked upon one side. In two of his cases he had presumption of nephritis localized in a single kidney; in the other three the inflammation affected both kidneys. One of these latter died within forty-eight hours, but the other two recovered and in spite of the bilateral lesions, the quantity and quality of their urine, showing marked changes before intervention, returned to normal. This surprising result he thinks explained by the reflex influence of lesions in one kidney upon its congener.

NEW YORK DERMATOLOGICAL SOCIETY.

303D REGULAR MEETING, FEBRUARY 25, 1902.

JAMES M. WINFIELD, M.D., *President.*

A Case of a Peculiar Disease of the Scalp.—Presented by DR. H. G. KLOTZ.

The patient, Eva Th., 8 years of age, born in Russia of Hebrew parents, was brought to the German Dispensary on Jan. 28, by her mother, who could give but little information in regard to the development of the conditions on the scalp. She reported that she had noticed about 3 or or 4 weeks ago that the child's hair was rapidly disappearing and that the girl complained of moderate pains when lying down on her head. The child had always enjoyed fair health and although somewhat anemic was well nourished and free from other complaints. On operation it was found that the dark blond hair, which apparently had been present in the quantity and quality usual for children of her age, had disappeared from the larger part of the scalp, leaving large bald areas of irregular shape and size, mostly confluent. The skin itself showed a smooth, lead surface without any distinct change in the epidermis, as scales, crusts, vesicles, pustules, etc., but irregularly distributed over the entire scalp there were seen numerous circumscribed but not sharply defined spots of a dark bluish red color, separated by normal portions of skin. To the touch these spots were distinguished by considerable softness which suggested the presence of some fluid underneath the thinned skin. On some places the softened portion seemed to communicate with each other under the healthy portions of the skin, as a pressure on the one would produce a distinct bulging out of a neighboring area. Much to my surprise on puncturing the softened places in different localities and on different occasions no pus was ever found but invariably some dark blood would flow out and continue to ooze for some time. Unfortunately I had no opportunity for making a microscopical or bacteriological examination of this blood.

The conditions somewhat resembled certain forms of subcutaneous gummata I have occasionally observed, but neither the history nor the further development of the disease furnished any substantial reason for the diagnosis of syphilis. The treatment principally consisted of moist applications with a 1-3000 solution of the bichloride of mercury and inunctions of the scalp with the ointment of the white precipitate of mercury. During the last two weeks the syrup of iodide of iron was given internally in moderate doses. Now the condition is already greatly improved, but few of the soft dark red spots can be found, while others more whitish, slightly depressed, quasi-cicatricial are found.

DR. A. R. ROBINSON thought the case was dependent upon staphylococcic infection, even though no localized suppurative lesions have been seen. He had shown a very similar case to the society a short time ago, and suppurative lesions developed later.

DR. L. DUNCAN BULKLEY agreed with the diagnosis made by Dr. Robinson. He had seen two or three similar cases lately, with superficial abscesses, often with very little pus, and patches of baldness.

DR. E. B. BRONSON said that the case must be some form of infection, but it seemed strange that there should not be more pustulation.

DR. J. A. FORDYCE thought the case was well worthy of considerable study and investigation from a bacteriological standpoint. The ringworm fungus should certainly be excluded by microscopical examination.

DR. S. LUSTGARTEN thought the case was a local, subacute infectious condition of the skin. It was not necessary to have pus formation. The process seemed rather too acute for ringworm or for infection of the hair follicles, nor was the appearance of the hair such as to suggest such an infection.

DR. H. H. WHITEHOUSE said he was inclined to agree with Dr. Robinson's conception of the case. The acuteness of the process and the amount of damage done, even though there was no pus formation, seemed to support that view.

DR. GEORGE THOMAS JACKSON took the same view as Dr. Whitehouse.

DR. KLOTZ said that in the main he agreed with Dr. Robinson in the opinion that the conditions were due to the infection with some coccus. The fact that the treatment which he had employed was principally a disinfecting one pointed to such a conclusion. It was remarkable, however, that no formation of pus had taken place in the subcutaneous tissue and no breaking down of the skin. He could not discover the slightest evidence of a folliculitis in the case, the surface of the skin at all times remaining smooth, free from scales, crusts, etc.

DR. BULKLEY asked for the experience of others regarding the regrowth of the hair in such cases.

DR. KLOTZ replied that he could not find any swelling of the roots of the hair or other evidence of inflammation upon the root sheath; the hair simply seemed to drop out, as he believed, owing to the temporary interruption of the regular supply of blood. He would expect in time a new growth of hair, although some small areas might remain bald for some time, but would gradually become overgrown again with hair.

Atrophoderma Neuriticum.—Presented by DR. A. R. ROBINSON.

Patient, a young man, fell and injured scalp near median line area anterior fontanelle one year ago. Eight months later hair fell out in areas about 2½ inches in length and 1½ in breadth at widest part. The bare area was egg-shaped and extended to near edge of hair limit on forehead. This area was depressed and atrophied. There was scar tissue, although ulceration had not taken place. An area of atrophy about ½ inch in diameter extended to near the root of nose and slightly to right of median line. There was also a slight fan-shaped area of atrophic skin to the right of this with small part next the hair. There were no subjective symptoms. The case will be published and illustrated.

DR. FORDYCE thought the definition given by Dr. Robinson covered the ground. It was probably a neuritis followed by skin atrophy.

DR. E. B. BRONSON said that he was pleased that Dr. Robinson had not called the case morphea. A number of similar cases had been presented at the London Congress, and had been labeled morphea. Dr. Bronson referred to a case which he had presented to the society, that of a man who had once had syphilis. After a time two ulcers had formed on the top of the head, and had been exceedingly difficult to heal. In connection with the ulcers, and in the same line, was a line of atrophy having the identical position of that shown in Dr. Robinson's case just presented. The ulcer was simply indolent when he saw it, and presented

no characteristics of syphilis. It had probably resulted primarily from inflammation of a nerve.

DR. E. L. KEYES thought it was very clear that the cause was traumatic and that the patient was neurotic. Close questioning showed that the injury had not been very severe, and it was probable that his neurotic condition had as much as the injury to do with the lesion presented.

A Case for Diagnosis —Presented by DR. J. A. FORDYCE.

The patient, sixty seven years old, had suffered from senile tremor for an indefinite time.

He had noticed an itching eruption on his body for the past year.

Examination showed a circinate and gyrate eruption over the back particularly the gluteal regions, the lower part of the abdomen, the thighs and upper extremities. The eruption was very superficial, the margins being made up of flat angular papules, while the enclosed centers of the marginate patches was slightly pigmented and atrophic. The color of the papules was a dull red, somewhat darker on the lower extremities. There was little scaling present.

The eruption was an unusual one and presented certain features of an annular lichen planus.

DR. KLOTZ stated that as far as it was possible to make a diagnosis in such a case without longer observation, he would make that of dermatitis herpetiformis. The presence of the numerous patches of papular elevations on some spots slightly resembling urticaria, the considerable itching, the appearance of new patches at intervals, and the disappearance of others, the extension of the trouble over several years apparently furnished all the important features required for dermatitis herpetiformis. The fact that only papular no multiform, lesions were present would not invalidate the diagnosis, as in other instances only vesicles or bullæ had occurred.

DR. G. T. JACKSON could not agree with the diagnosis of dermatitis herpetiformis, for he had never seen a case of that disease presenting such an appearance. Nor did it resemble lichen planus or a papular syphilide. He called attention to the decided tendency to the formation of rings with raised edges and peculiar blue red color, and added that he was inclined to look upon the case as one of persistent exudative erythema.

DR. ROBINSON said that he had seen this man at one time, and recalled the fact that he had made a diagnosis of dermatitis herpetiformis. From its present appearance he would still expect it eventually to develop into a more classical case of dermatitis herpetiformis. He had the photographs of a case showing well the ring forms alluded to. The ring formation, the multiformity of the lesion and the itching seemed to him to confirm this diagnosis. He did not see the remotest resemblance between the photographs presented by Dr. Fox and this case.

DR. BUTLEY said he did not see how one could escape from the diagnosis of dermatitis herpetiformis Duhring had described many such cases in which there were no vesicular lesions, their presence or absence depended entirely upon the severity of the process He saw no reason for thinking the case one of lichen planus, for he had never seen that disease with so many urticarial lesions; moreover, with this amount of eruption there should be some of the primary single lesions, which was not the case here

DR BRONSON said it seemed to him more like dermatitis herpetiformis than any other disease. It was distinctly an angioneurosis The disease under dis-

cussion seemed to him totally different from the photographs presented by Dr. Fox. The periphery of a certain area showed the eruption and the center was clear, whereas in the photographs the whole surface was roughened, there being apparently a keratosis present. In its nature it appeared to be an erythema. The papules were soft and unlike those of lichen planus, and there was evidently very little multiplication of the epidermis. Duhring had described a great variety of lesions, some of them erythematous, under the name of dermatitis herpetiformis. It was perfectly possible for the subjective symptoms to vary with the nature of the lesion. As a rule, an erythema does not itch much, while a vesicular disease does itch a good deal. Most of the cases of dermatitis herpetiformis were vesicular, and hence we were accustomed to consider severe itching a necessary part of dermatitis herpetiformis. The case seemed to him to answer in all its characteristics to the definition given by Duhring of dermatitis herpetiformis.

DR. S. SHERWELL said that the clinical picture did not seem to him at all like Duhring's description of dermatitis herpetiformis. The case presented a cribriform appearance, and he had never seen this so distinctly in dermatitis herpetiformis. He did not think it was lichen planus, but he did not feel at all sure regarding the diagnosis, though the case suggested to him a persistent multiform erythema.

DR. WHITEHOUSE said that he thought he had seen evidence on the back of lesions of lichen planus, and it was possible at least that the case was one of lichen planus annularis.

DR. FORDYCE said he would exclude the disease shown by Dr. Fox, pityriasis rosea, which presents a scaly condition of the skin, not present in the case under discussion. In the latter there was a distinctly papular condition. Again, he had seen a fair number of cases of dermatitis herpetiformis, but not one of them resembled the disease in question. Here there was one type of lesion throughout, while dermatitis herpetiformis is a multiform eruption. He did not think there were any urticarial lesions in this case. The lesions begin as an infiltration of the derma, the centre of which clears up, the disease spreading marginally. The disease seemed to him to conform more closely to annular lichen than to any other disease. He had presented a somewhat similar case some years ago. In the center of the patches there was sometimes a recurrence of the papules, and that was what was taking place in the present case.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

Wednesday Evening, February 19, 1902.

JOHN VANDERPOEL, M.D., Chairman.

Prostatectomy Forceps.—DR. GUITÉRAS.

The instrument which I present to you resembles very much a pair of sponge forceps, excepting that on the handle there is a long arm with a number of notches on it, as is seen on tongue forceps, which makes it possible to grasp any sized gland with it without injuring it. The blades are oval and fenestrated in the center, and are serrated on the inner surface. The shafts running from the

blades to the pivot are thin and somewhat separated when closed. The two illustrations which I present demonstrate the manner of using the instrument.

In plate No. 1 the forefinger of the left hand will be seen in the rectum, while a pair of sharp pointed curved scissors held in the right hand will be seen passing through the perineal urethrotomy opening, and in the act of cutting the floor of the prostatic urethra at the apex of the prostate.

Plate No. 2 shows the forefinger of the left hand inserted into this cut, sweeping it around between the lobe of the gland and the capsule, while the former is being held and gently drawn down by the forceps held in the right hand.

I should also like to call the attention of the gentlemen present to the prostate and bladder in these illustrations, the drawing was made from a frozen cadaver of a man who had been castrated some two years before for enlarged prostate. When a vertical section was made in the antero-posterior diameter in the median line through the bladder and prostate, with the former viscus empty, it was noted that the walls of the bladder, perhaps somewhat thickened, had collapsed, the cavity being about the size of a French pea. When this was thawed out by applications of hot water it assumed different shapes during expansion, the one that you see here is probably made when the cavity was sufficiently large to hold one or two ounces. I made several drawings of the bladder in different stages of dilatation which I shall be glad to present on some other occasion before the Society, as there is no text-book that I have ever seen which contains such drawings.

DISCUSSION ON DR. GUITÉRAS'S FORCEPS.

DR. GREENE.—I want to thank Dr. Guitéras for not only showing the instrument but for bringing these plates, which are very clear and help one a good deal in understanding this particular method of operation.

DR. BROWN.—I want to ask a question, not with reference to this immediate operation, but with reference to one point in perineal prostatectomy, as to how frequently it occurs after shelling out the prostate and relying upon the perineal incision alone when the tube is removed, whether it occasionally happens that the point of the perineal tube gets caught in the capsule and in the cavity of the enucleated gland, and whether it is somewhat difficult to have it enter the bladder when taken out for cleansing.

DR. VANDERPOEL.—The plates are certainly very instructive, and it is an excellent method of showing the steps in an operation to draw them or have them sketched. Perhaps a photograph would be more definite, but this certainly gives one an excellent idea of the various steps.

DR. GUITÉRAS. Prostatectomy by this method is indicated only in cases where the gland is large and low seated as determined by rectal examination, and is not recommended where there is a large growth extending up into the prostatic urethra and neck of the bladder

When the lateral lobes are removed by this method through the incision made in the floor of the prostatic urethra, I catch the cut edges of the prostatic urethra on either side with artery forceps, and pass a gorget into the bladder between them, a perineal tube is then slipped in along this instrument. The perineal drainage tube that is used is a stiff walled soft rubber catheter from 38 to 42 French. I allow this to remain in for eight or ten days, then I remove it and insert a smaller one, which I leave in for another week, after which I pass a catheter through the anterior urethra into the bladder and allow it to remain

there until the perineal tissues have closed around it, during this time I give the patient urothropin and a large amount of water and dress the wound twice daily, washing out the bladder through the retained tube or catheter each time with boric acid solution and once a day with 1-4000 nitrate of silver solution.

Radiographs of Vesical Calculus with Specimen.—Dr. Vanderpoel.—I have two radiographs here of different stones or of parts of same. In these cases the stones are of different forms. The first one you see here is this calculus, this specimen I have here, the nucleus of which seemed to be of carbonate of lime and the rest of the stone of amorphus or earthy phosphates. The stones was very easily removed. It was seen first by cystoscope easily, and easily removed afterwards by suprapubic cystotomy. The specimen I have here has been opened and you can see the calcium carbonate nucleus. The calcium carbonate, as I understand, is rather rare; in fact, it is quite rare to get one with as large a nucleus as this one shows here. The other one is pushed over and I have not operated as yet, but the stone has been diagnosed as oxyalate of lime stone. I have seen it with the cystoscope; very easily felt. The exposure in each is about ten minutes. This one at the upper part is under exposed. This one, as you see, is somewhat darker than the other; it is about the same size, a little broader, and as seen through the cystoscope is a very dark green or almost black in appearance. It was impossible to get a picture of the entire stone at once. I could only see one corner or one edge at one time. As I say, the patient has not yet been operated upon. These radiographs were made by Mr. Caldwell in the laboratory of the University in Bellevue Hospital Medical Clinic. The photograph here is a photograph of the stone which you see. It has really no special value excepting as a matter of record. It is, however, a very good photograph and gives a very good idea of the stone as it was.

Dr. Guitéras.—What position was the patient in when these photographs were taken?

Dr. Vanderpoel.—The patient lay upon his abdomen, and the picture was taken at an oblique angle of 45 degrees.

Dr. Guitéras.—That is a very interesting point because these stones show much more plainly than if the patient were standing up.

Dr. F. Tilden Brown.—I am interested to see, as shown in these pictures, that phosphatic stone casts much less of a shadow than the oxyalate of lime. I think that is contrary to the usual expectation, is it not?

Dr. Vanderpoel.—The diagnosis of the stone was simply made through the cystoscope; it was a mulberry stone and had all the appearance of an oxyalate of limestone, the color and appearance and feeling to the searcher. The print shows the stones removed from the bladder, where there was a large middle lobe and two large lateral lobes. It was a case of considerable interest to me because in consultation my consultant thought this large median lobe was a right lateral lobe. I had the opportunity of asking him to insert his finger in the bladder at the time the stone was removed and at the time of suprapubic prostatectomy, and he was satisfied, as was I—I wasn't positive it was a median lobe and the reason he thought quite positively it was a lateral lobe was because in looking upwards there was a dense margin leading off to the right hand side and high up. It looked to me as though it were a median lobe. He was positive in his assertion that it was a right lateral lobe,—thought possibly it was a right lateral lobe which had grown out there in a pedunculated fashion and into the median area of the anterior bladder. It proved to be a

median lobe with a fold of mucous membrane, a veil, as it were, reaching up pretty nearly to the upper margin of the left lateral lobe. There was some doubt also as to the operation which was performed in this case. I took the position that what ought to be done was a suprapubic cystotomy for the removal of the stone and at the same time utilizing the incision for the enucleation of the lobes. My consultant thought very strongly that a crushing operation with a combined Bottini was in question, although he admitted that it was radical and that it might have to be repeated, either the crushing of the stones or the Bottini operation. He thought it was a little safer for the patient, a little less risk, and I thought that the additional risk, whatever it might be, was justified in view of the greater chance of radical result. These stones could only be seen—the middle lobe reached over these stones so much that only the margin of 3, possibly 4, could be seen—although I thought there was probably a good deal of a pocket—I was hardly prepared to remove 4 or 5 stones. The age of the patient was 60 years.

The Nature of Prostatic Hypertrophy.—By ROBERT H. GREENE, M.D., and HARLOW BROOKS, M.D.—The paper published in full in the Journal of the American Medical Association, April 26, 1902, the writers' review of the literature on the subject during the last five years and consider especially the work done by Chikanowski, Albarran and Halle, and Motz. They state that for the past twenty years Prostatic Hypertrophy, although the various investigators have differed as to its type, has been considered as due to a tumor of some sort, either adenoma, a myoma or a fibroma. They mention Chikanowski's work as tending to show that these growths are an inflammatory product, and the senior writer's confirmation of his views, as stated in a paper read last June before the American Medical Association entitled "Fallacies in the Treatment of Urethral Diseases." They differ with the views of Albarran & Halle as to the true nature of what is termed by them adenoma carcinoma, but give them credit for having called the attention of the profession to the fact that cancer of the prostate is more common than has generally been supposed. They then give a detailed history of the appearance of the sections made through fifty-eight hypertrophied prostates as the result of an examination of prostates running into the hundreds in number. Of the fifty-eight hypertrophied prostates examined by them, they either had or were able to obtain the clinical history of nineteen. Quite a number of these prostates had been removed at operation. These further studies of theirs tended still further to confirm the views of Chikanowski that an enlarged prostate was due to an inflammatory lesion and that the enlargement depended according to what part of the prostate the lesion was situated in. If outside the acini in connective tissue form, a small hard prostate would result. If over the mouths of the acini, the acini would be dilated and a pseudo adenoma but not a true adenoma would result, and what had been considered a muscular overgrowth was due to an infiltration of the muscular tissue by connective tissue and was not a true muscular increase. Often a single gland showed several types. The most common lesion was interstitial hyperplasia.

The next in importance, present in 30 out of the 58 cases, was inflammatory infiltration. No cases of true glandular or muscular hypertrophy were found. Three fibromas and three cancers were found in the 58 cases examined, but these were apparently secondary to the preceding inflammation. The inflammation in these cases was apparently consecutive to an original posterior urethritis. Stereopticon views of sections made through 13 prostates were shown, showing

the gradual progression from a chronic prostatitis to a cancer of the prostate. The writer's conclusions were as follows:

CONCLUSIONS.

(1) Prostatic hypertrophy of the aged is the result of chronic prostatitis.

(2) It most frequently arises from chronic posterior urethretis of whatever cause.

(3) True neoplasms of the prostate are rare and are not concerned in the production of prostatic hypertrophy.

(4) Carcinoma is apt to occur in the hypertrophied prostate as a result of the chronic inflammatory process.

DISCUSSION.

DR. BROWN.—I have very little to say on this subject, certainly nothing to add to that which has been so beautifully set forth by the reader of the paper and by the expounder of the plates. I express my pleasure at having heard this most instructive dissertation on a most interesting subject. I have learned more from what I have heard to-night than from any similar presentation I know of. I haven't followed the matter up from this same standpoint and do not feel prepared to make any comments upon the probability of the grounds taken by Dr. Greene in his paper. I am particularly interested in Dr. Brooks' demonstration and wish to thank him for the expression of his views concerning the origin of corpora amylacea in the prostate. I think that although recognized they have been passed over as a concomitant of the prostatic trouble and very little said about them. I have often been annoyed in looking up works on histology to find their presence alluded to but they had not attempted to explain their form. It seemed to me that that one plate carried a great deal of evidence in its morphology in support of the statement here affirmed that they are formed by the compression of cast-off epithelial cells.

DR. MORTON.—I can only express my thanks to Dr. Greene and Dr. Brooks for the valuable work which has been set forth here this evening. I think that those who realize that the text-books in speaking of the hypertrophied prostate give us little or nothing on the subject will appreciate that a great deal of light has been thrown, it seems to me, on the histology of the enlarged prostate, and light which we have never suspected before.

DR. LAPOWSKI.—I have learned this evening more than at any other meeting. Before beginning my remarks I would like to direct the attention of the reader of the paper to the fact that Chikanowski's paper was published in 1898 in Polish, then translated and published in German in 1900. When I directed the attention of our Society to the conclusions of Chikanowski's paper in 1898 a member of our Society objected to his conclusions as not being substantiated or proved by any other investigator, and I am glad to hear this evening Dr. Greene and Brooks came to the same conclusions in their investigations as Chikanowski. From the picture shown by Dr. Brooks and from his explanations a clinician can learn a good many things. He will have to modify not only his treatment of prostatic hypertrophy but the prognosis of the disease, especially in the chronic cases of prostatic hypertrophy. Dr. Brooks showed us that new connective tissue is developing around the duct of the glands, compressing it, and in this way preventing the contents of the glands from evacua-

tion. In such conditions very little can be expected from massaging and compressing of the gland through the rectum with the view of expressing the contents of the glands. Even full absorption cannot be expected, as Dr Brooks showed to us that the blood vessels in the connective tissue are very little developed.

Another clinical point is made clear to us by these investigations—the hard and soft prostate. When the connective tissue is developed around the acini of the glands and not at the mouth of the glands, then we will have a hard prostate. When on the other side the developed connective tissue presses the mouth of the duct, then the acini of the glands transforming themselves in cyst-like formation will give us the sensation of a soft prostate. All as we see depends upon the place of the new formation of connective tissue.

The next important point in Dr. Greene's presentation is the fact mentioned first by Albarran that some hypertrophied prostates in their latter stages develop clear characteristics of a cancerous growth; that there are patients who at a given period of time will only present a plain hypertrophy of the prostate and the same patients to years later develop an epithelomatous prostate. The reason of that change is not clear to us, but judging from analogy I believe that such cases are due to irritation to which the prostate was exposed. We can see such analogies in glands of the skin where a plain wart or nevus gradually changes into a malignant growth. We see some benign epitheliomata will change into malignant forms. We see leucoplasia upon the tongue changed into malignant growth, and in all such cases we avoid irritation, knowing that we might give an impulse to malignancy of the growth. Dealing, then, with a hypertrophied prostate we must have the same fact in our mind and not to add to the irritation produced by the presence of the chronic gonorrhea, which is the primary cause of hypertrophied prostate, other instrumental irritations in trying to influence a process which according to Dr. Brook's microscopical pictures cannot be influenced by any manual or instrumental irritation.

In trying to find the cause of hypertrophy of the prostate many clinicians do not dare to trace it to the attacks of gonorrhea, while all other points, clinical as well as microscopical, warrant such conclusion; and here I would suggest one point to the writers who report cases of prostatic hypertrophy, to note in every case not only the general condition of the patient, but to investigate positively how many attacks of gonorrhea the patient was exposed to and what kind of treatment he received during the attacks.

In the end, let me thank, Mr. Chairman, the readers of the paper for their scientific contribution to our Section.

DR. BIERHOFF.—It is seldom one gets an opportunity to thank the reader of a paper at our medical societies without criticism, and I think we are to be congratulated this evening upon having listened to this one, which we can praise in every respect and criticize in none. I am especially thankful to the reader of the paper and to Dr Brooks who demonstrated, for the additional interest this paper has given me from the fact that it supports me in a view I have held for some time, that is, that the inflammatory conditions of the prostate in the sub-acute stage were too little recognized, whether due to gonorrhea or to other inflammatory conditions, or to chronic congestions. The main point in the paper is, as I understand it, that prostatic hypertrophy is due to the results of inflammatory conditions affecting the posterior urethra, or the prostate. I have been pleased to see that the authors have not been led into the error of saying posterior urethritis of gonorrheal character, because I believe these

chronic gonorrheal processes are only a part of the congestive and inflammatory conditions which lead to hypertrophy. The additional value is that they have given us in so clear a manner the character of the process itself. I believe they make the indications very much clearer than has been heretofore the case. I think that when we have listened to a paper of this sort we see that it is possible for us by judicious treatment directed toward acute and subacute congestive or inflammatory processes, to do much in the prevention of chronic inflammatory changes.

DR. TOWNSEND.—I would add my thanks to those already expressed to the authors for the instruction received from the paper.

A point regarding the diagnosis of cancer of the prostate, associated with prostatic senile hypertrophy: Heitzman holds that in those cases in which the ducts of the follicles are still pervious, repeated examinations of the urinary sediment will show polynuclear epithelia from the prostate gland, with greater or less number of connective tissue shreds. The same author says that in all cases of carcinoma in the genito-urinary tract, including those cases of cancer of the prostate in which the ducts leading from the infiltrated portion are still pervious, repeated examinations of the urinary sediment will show cancer epithelia. These epithelia are irregular in outline, polynuclear, coarsely granular and range in size from the epithelia lining the pelvis of the kidney to those from the middle layer of the bladder. Occasional agglomerations of three to five of these epithelia may be seen, which the author terms "cancer-nests." Large shreds of connective tissue of fantastic outlines are found in addition to the epithelia.

Doubtless this important point in diagnosis will be absent in certain cases. In these there is an obliteration or occlusion of the prostatic ducts which lead from the follicles in the cancer infiltrated portion of the gland.

FERD. C. VALENTINE.—From the clinician's viewpoint, the paper offers much food for serious thought. The authors are exceedingly conservative in the deductions they make from so searching a study. Among these is the one that prostatic hypertrophy seems to originate or to have its point of departure from posterior urethritis, and, as we all must accept, posterior urethritis is due, most frequently, to gonorrheal infection of the anterior urethra. To prevent even unintentional misguidings as concerns my intentions, I must here stop to say distinctly that prostatitis of gonorrheal or other origin is not under discussion. The authors' statement, to which I have referred, would lead us to look to gonorrhea for the prime causes of senile hypertrophy of the prostate. I do not deny that for many reasons patients, especially when of the age that so often unhappily brings with it prostatism, are prone to forget unfortunate experiences of a gonorrhea in the dim past. It therefore is possible that some of our patients may, let us be charitable enough to think so, have really no recollection of one or more gonorrheal infections. But the authors nowhere say that in any of the 58 prostates so carefully examined, did they find even traces of gonococci. It is true that the spendid pictures projected on the screen show what I estimate to be a magnification of only 500 to 600 diameters; still even with this low power we should be able to have seen a suggestion of gonococci, had they been present in any part of the specimens. I do not deny that many of the patients whose prostates were the subject of the authors' studies, may have had gonorrhea and perhaps many attacks. If they had, and the authors' work when published in full will probably show that many did, then they have refuted the assertion of those who hold that the gonococcus is uneradicable. As

far as I am concerned, this magnificent paper supports the view I have often advocated here, namely that gonorrhea is not an incurable disease. In this connection I may be permitted to correct a statement, made some years ago, by one member who, alluding to gonorrhea, said that "there are some who designate gonorrhea a trifling disease, easily washed away with a few irrigations." I am not aware that any serious student of genito-urinary diseases ever made any assertion by which gonorrhea could be misinterpreted as anything else than a serious ailment. Nor did any one, to my knowledge, ever say that gonorrhea could be or ever was "washed away with a few irrigations." As, however, in the light of ever-increasing experience, properly conducted irrigations continue to be the best, most effective and promptest method of combating gonorrhea thus far known, there seems no practical reason why they should be so sweepingly condemned, except by those who will not give themselves the trouble to carefully carry out the not at all difficult technique, who prefer to adhere to the useless and injurious internal administration of drugs and trifling or painful injections with syringes. However, to revert to the subject that is really under discussion now, and the clinician's viewpoint concerning it, I have nowhere seen in literature the assertion that those given to sexual intercourse throughout a long life are less prone to senile prostatic enlargement than are those who led virtuous lives. The fact, however, remains that the greatest sufferers from large senile prostates that I have seen were men who had gone chaste to the marriage-bed and who after marriage led most exemplary, moral lives as husbands and fathers. It so happens, as is natural with one seeing very many cases of gonorrhea, its complications and sequelæ, that very many gonorrheal prostatites, acute and chronic, and abscesses of this organ should come my way. It is equally natural that I have during more than a quarter of a century of practice met many men who led the very opposite of moral lives. I do not remember one of these roués who complained, even in advanced years, of the slightest prostatic trouble. Far be it from me to even intimate that sexual profligacy may be a prophylactic of senile prostatic enlargement. I offer the experience, which may be purely individual, for the examination of better investigators and more competent students. In conclusion, I ask the distinguished privilege of felicitating the profession on having received from Drs. Greene and Brooks so valuable and important a chapter to our literature, as they have presented.

DR. VANDERPOEL.—I thoroughly agree with Dr. Brown that it is almost impossible to discuss this subject unless one has personally had experience in making sections of prostates, that is, as regards microscopical examination.

The point as to whether the prostatitis or whether the enlarged prostates are inflammatory or not is certainly most interesting. It is hardly possible, however, for one to discuss that subject unless one has personally made sections of the prostate. I must congratulate the authors of the paper, both Dr. Greene and Dr. Brooks, upon their successful work and also congratulate the section upon the advantage of having heard the results of their work, which are by far the most thorough and far reaching of any we have ever had before this section.

DR. BROOKS.—I can only thank you for your very kind remarks. I think that Dr. Lapowski has expressed a great deal better than I could the ideas Dr. Greene and myself have held. I took up the work at the suggestion of Dr. Greene to refute these ideas as not in keeping with what I had read and found myself from examinations. In studying sections of the prostate it is a

great mistake to examine only occasional specimens for one is apt to deceive himself in that way. It is only after studying a good many sections consecutively at one time that one can arrive at correct conclusions, and I think if any one will do that, he will convince himself very readily that the hypertrophied prostate is not a new growth. I thank you for your kind attention.

DR. GREENE.—I am deeply gratified at the favor with which our paper has been received. For the two other papers which I read on the subject several years ago I have not the same cause for congratulation. In the remarks that have been made I wish to say that we have tried in the paper to be careful in our statements and we have endeavored not to in any way befog any real work we have done, if we have done any, by stating ideas which we might believe to be true, but were not in position to demonstrate. Dr. Lapowski has stated very clearly, and more clearly than I feel sure we could ourselves. Anything that we may hope to obtain from the paper, and that is if it helps us in any small way to find out a little more about these conditions of the deep urethra and of the prostate and to know a little bit better about what we are doing when we treat patients, either with posterior urethritis or with the hypertrophied prostate of the aged, than we do at present in any way, it will fulfill everything we have hoped from it.

I do not mind saying in the discussion one or two things which were not in the paper and are simply my own opinion, so far as opinion goes. You can take it for what it is worth. Our work, as far as we could go, showed that prostatic hypertrophy is an inflammatory condition. The idea that a man may have gonorrhea a great many times and not have hypertrophied prostate is not a new idea. Ultzman has been quoted as saying gonorrhea prevented hypertrophied prostate. One of the first cases that ever made me think in years gone by that prostatic hypertrophy was in any way due to inflammation was a man who lived in Washington and came to me in my earliest years of practice; has been coming to me ever since once or twice a year. I have watched him for a good many years and I saw him go from an ordinary chronic prostatitis following gonorrhea, right straight along into prostatic hypertrophy of the aged, so that within the last five or six years he has taken to catheter life. My personal experience is entirely different from the experience Dr. Valentine stated to be his. I have certainly seen cases of men apparently who never had gonorrhea who complained of difficulty in micturition. I haven't been able to make up my mind whether those were cases of true prostatic hypertrophy or whether these were cases of congestion giving rise to hard edema outside of the prostate or of loss of muscular tone of the bladder. I have never seen one of them so badly off to necessitate an operation. As far as we have a history of the cases recorded in the paper almost all have had gonorrhea. Apparently the inflammation starts in the posterior urethra and we believe that whatever may cause the inflammation of the posterior urethra, not necessarily gonorrheal, may give rise to prostatic hypertrophy. I do not believe it is always gonorrhea, and it is very possible, too, that a good many gonorrheas give rise to more or less prostatic atrophy.

DR. LAPOWSKI.—It is hardly possible to agree with Dr. Valentine's statement that gonorrhea does not produce an hypertrophied prostate.

In the present state of our knowledge of the causes of an hypertrophied prostate, we neither can deny or affirm the important, active rôle of the gonococcus. We lack both clinical observations, and microscopical and bacteriological investigations upon a larger scale, than hitherto undertaken.

To the clinical histories of hypertrophied prostates reported by writers, few pay attention to the question of the previous existence of a gonorrhea. On the other hand there is, to my knowledge, not one case reported where a hypertrophied prostate existed and the further presence of gonorrhea excluded with certainty. It is hardly possible to expect to find with our present staining methods a living stainable gonococcus in the tissues of a degenerated prostate, the soil of which is not appropriate for the growth of the gonococcus. But we see in a hypertrophied prostate morphological changes, which are exactly alike to the pathological changes produced in other gonorrheal processes as regards the time of their appearance and their anatomo-pathological forms. Strictures of the urethra of post-gonorrheal origin appear later, and not only the changes confined to one portion of the urethra, they do not spread by continuity, but they are disseminated as are the changes in a hypertrophied prostate.

Selections.

The Changes of the Thyroid Gland in Patients Suffering with Syphilis During the Second Incubation and During the Period of Eruption. —A. P. POLOTAVTZEF (Prof. Zehner's Clinic) (*Russian Jour. of Cutan. & Ven. Dis.*, Vol. I., 1901, p. 85.)

Eighty-five patients afflicted with syphilis formed the basis of the writer's paper. In forty-five patients the changes of the thyroid gland have been noticed before the appearance of the early eruption. In the remaining forty the measurement of the gland began with the outbreak of the syphilitic rash, usually the measurement was taken simultaneously with the weight of the patient.

The author arrived at the conclusions that (1) the thyroid gland is not indifferent to the circulation through the body of a syphilitic poison. The gland takes part in the disease, and (2) sometimes its involvement can be demonstrated by its increase in size; (3) this increase is not always a passing one, sometimes it leads to permanent changes (colloid degeneration—in the writer's case—autopsy). The increase in size usually begins simultaneously with the appearance of the eruption and reaches its maximum when the eruption is at its height. In some cases where changes in the action of the heart were marked during the period of early eruption, the thyroid gland was usually found enlarged.

The Question of Immunity of Animals to the Bacillus of Soft Chancre —By T. GIMMEL (Metchwikov's Laboratory) (*Russ. Jour. of Cut. & Ven. Dis.*, Vol. II., 1901, p. 306.)

The writer's aim was to cultivate the bacillus upon accessible media, explain the conditions of animal immunity and by increasing the virulency of the bacilli and decreasing the immunity of the animals, make the animals susceptible to the infection. He succeeded in all the three points. Inoculating coagulated blood of guinea pigs with the exudation of the chancre he obtained in 6-8 hours a good culture of the bacilli. By the aid of lactic acid or antialexin the virulency of the bacilli is increased. It kills the guinea pigs when injected into the abdominal cavity in twenty hours. The same alexin diminishes the immunity of the animal, when injected into it.

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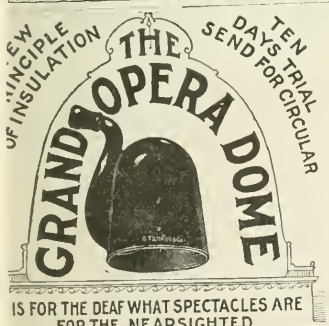
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